

**Centers for Medicare & Medicaid Services  
EHR Incentive Program Basics for Eligible Professionals  
National Provider Call  
Moderator: Diane Maupai  
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Operator: At this time, I would like to welcome everyone to the Medicare and Medicaid EHR Incentive Program Basics for Eligible Professionals call.

All lines will remain in a listen-only mode until the question and answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for your participation in today's call.

I will now turn the call over to Diane Maupai. Thank you, ma'am. You may begin.

## **Introduction**

Diane Maupai: Thank you. Good afternoon, everyone. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore, and I'll be serving as your moderator today. I'd like to take you to the Medicare and Medicaid EHR Incentive Program Basics for Eligible Professionals call.

Today, we have two CMS experts that have a lot of good information to share with you. And before we start our call today, I'd like to go into a couple of little details.

One, there is a slide presentation for this session. About 1:00 o'clock Eastern Time, an e-mail was sent to all people that registered for today's call, and it contains a link to the presentation.

So if you didn't receive that e-mail and you don't have the presentation, please check in your spam or junk mail folder for an e-mail from CMS National Provider Calls.

Today's call is being recorded and transcribed, an audio recording and a written transcript will be posted to the CMS National Provider Calls section. There's a link to where that's going to be in the e-mail that came out at 1:00 o'clock today. And you'll also find it on the Educational Materials section of the EHR Web site.

I'd also like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with the speakers to help us prepare the remarks for today's presentation.

At this time, I'd like to introduce our CMS speakers for today. We're pleased to have with us Rob Anthony who is a health insurance specialist for the Center for the – oops, wrong one – the Office of E-Health Standards and Services; as well as John Allison who is a health insurance specialist in the Center for Medicaid, CHIP, and Survey & Certification.

We have a number of topics to cover today and we'll be doing a little bit of a tag team. We're going to start with John, and then we'll be alternating with John and Rob to cover all the material.

So now, it's my pleasure to turn the call over to John.

## **Presentation**

John Allison: Great. Thanks, Diane, and thanks everybody for joining us. Good afternoon. It's afternoon everywhere, yes?

Diane Maupai: Yes.

John Allison: Way – all the way on the West Coast?

Diane Maupai: Well, thank you.

John Allison: Yes. Good afternoon, everybody. First, I would like to just mention the success that we've had in the last year with both the Medicare and Medicaid EHR Incentive Programs, which really showed that these programs have legs.

We have, since these programs launched in January 2011, more than 200,000 eligible professionals who have registered for the program so far, and more than 60,000 of those "EPs," as we call eligible professionals, have been paid. And this amounts to actually more than 1 billion that have gone out to eligible professionals participating in either the Medicare or the Medicaid EHR Incentive Programs.

So again, we're very excited by the success that we've had so far, and of course, calls like these will continue to facilitate additional success.

As Diane mentioned, we'll have Rob and I – we'll have a tag team. I'm going to start the call and cover some eligibility information, and Rob is going to address Meaningful Use, you know, have to – the term you probably heard many times, some of you may already know what it is, but we'll clarify that for you today.

Then, it will come back to me and I'll do a high level attest – excuse me, registration overview. After that, it's going to go back to Rob and he will discuss attestation. And then, we'll share some resources and I guess at that point go over to the Q&A session.

So, anyway, without further delay, let's go to the slide deck that everyone was sent out. So, OK, so let's see. Slide two is "Eligibility and Overview." So let me skip ahead to "Who is eligible to participate?"

So, the provider types, the eligible providers who can participate, this was determined by Congress and statute, as with a lot of the eligibility criteria, so, CMS really doesn't have much leeway to decide provider types or in the – into the – in the example of what I talk about how a hospital or how a provider is hospital-based and whether that hospital-based provider can participate in programs. But again, so eligibility was defined in the statute, hospital-based eligible professionals are not eligible for incentives. So this was a decision made by Congress.

An EP is considered hospital-based if 90 percent or more of their covered services are provided in either a hospital inpatient setting or a hospital emergency room setting.

We can tell – we can qualify – or quantify the hospital-based status by actually looking at the claims. And, a Place of Service 21 correlates with the hospital inpatient claims, a Place of Service 23 correlates with services that were provided in the emergency room setting.

So again, if 90 percent or more services were provided in one of those two settings, then an eligible professional, whether they're trying to participate under Medicare or Medicaid, is considered hospital-based. And, they are not eligible at that point to participate in the program.

And, one of the reasons for this is that hospitals are also eligible for incentives. So an EP who was providing most of their services, an eligible professional who's providing most of their services in the hospital setting, is actually helping up in that hospital reach or qualify to participate in the – either the Medicare or the Medicaid EHR Incentive Programs, just something to keep an eye on.

Incentives are also based on the individual, not the practice. That's also on the slide. So the eligibility requirements are applicable to the individuals, not to the group practice, not to the clinic, but – an eligible professional has to qualify based upon them meeting the requirements, standing alone.

We'll briefly talk later, this doesn't prevent an eligible professional from reassigning their incentive payments to their practice or clinic, wherever. But again, they have to qualify standing alone for the Medicare or Medicaid EHR incentive payments.

So jumping to slide four, this is a – it's a Venn diagram and it shows which eligible professionals can qualify for either the Medicare EHR Incentive Program – that's on the left, the part – the oval in blue – or the Medicaid EHR Incentive Program – that's what's in yellow, if you have color slides on the right; and then you see the overlap. These are the eligible professionals who could qualify for either program.

So, on the Medicare side – optometrists, podiatrists, chiropractors – these providers can only qualify under the Medicare EHR Incentive Program.

Whereas, on the Medicaid side – nurse practitioners, certified nurse midwives and physician assistants – under certain circumstances, the circumstances that they are practicing in a Federally Qualified Health Center or Rural Health

Clinic that is led by another physician assistant, these are provider types who can only qualify for the Medicaid EHR Incentive Programs.

Then we see in the middle the doctors – whether MDs or DOs, dentists, who else, yes, physicians and dentists – these are providers who could qualify for either the Medicare or the Medicaid EHR Incentive Programs.

Now something that's important to remember about EPs, about eligible professionals, even if they could qualify for either program, they have to choose. They cannot receive an incentive from both programs for the same year.

So again, providers would have to consider, you know, what makes sense to them. And something that we'll point out shortly is actually under the Medicaid EHR Incentive Program – eligible providers can receive a higher total benefit and they can actually participate in the program for a year longer. So something that – for you physicians out there who might qualify under either programs to keep in mind.

OK, so let's go to the next slide. This is – OK, this slide was just provided really for your reference. This is the hospitals who can participate in the Medicare and Medicaid Incentive Program.

Most hospitals can actually receive incentives under both programs. We're not going to go into this in detail. Since hospitals are going to have their own call, but again, this slide is – in your slide, that's for your reference. Just to cover all providers who could participate in the program.

OK, next slide. This is the eligible professionals' Medicaid patients. So as we've already indicated, to participate in the Medicaid EHR Incentive Program, the eligible professional must either be a physician, whether MD or DO, a nurse practitioner, a dentist, a certified nurse midwife, or a physician assistant practicing in an FQHC or a RHC that is led by other physician assistants.

So, that's the first criteria being a provider has to be one of those provider types in order to receive a Medicaid incentive payment.

Also, since they are Medicaid providers, they have to have either 30 percent Medicaid patient volume and for a 90-day period in a prior calendar year. This is to make sure they are actually seeing Medicaid patients since you're going to be paid under the Medicaid EHR Incentive Program.

OK, so either a 30 percent Medicaid patient volume or if they are a pediatrician, they can have between 20 and 29 percent Medicaid patient volume and still qualify for an incentive under the Medicaid programs. Or, if they are practicing predominantly in a FQHC or RHC, I will come back and define what "practicing predominantly" means, they can have 30 percent needy individual patient volume, and qualify for Medicaid EHR incentive.

So, needy individual patient volume, this is a much broader category than just Medicaid. This includes Medicaid patients. This also – it includes CHIP, people covered under CHIP. This includes patients who receive discounted services on a sliding fee scale – patients who are provided services who – the services aren't reimbursed to the provider.

So, OK, needy individuals, that's for providers who are practicing predominantly in FQHC or RHC. Again, they have to have basically qualified based upon the needy – 30 percent needy individual patient volume.

What practicing predominantly means is that a provider has 50% of their total encounters over a period of six months in the most recent calendar year in a FQHC or RHC. So again, 50 percent total encounters over a period of six months have to be in either the FQHC or RHC for a provider and eligible professional to be considered practicing predominantly.

Also on the slide, and this is now true for both Medicare and Medicaid, providers have to be both licensed and credentialed. They can't be on any HHS, Office of the Inspector General Exclusion or extension list.

They have to be living. That sounds funny, but we do check, again, the Social Security Master Death Index to make sure that the provider is alive and, as we already said, the provider cannot be hospital-based.

OK, the next page – the slide – the slide seven, and this is hospital eligibility again which we are going to skip for now.

So the next slide after that is this – the Medicare basics for an eligible professional. So again, as we indicated, under the Medicare EHR Incentive Program, EP would have to be a physician, whether an MD or DO, a dentist, an optometrist, a podiatrist, or a chiropractor. And here's one of the extension, they have to have allowed charges under Part B – Medicare Part B allowed charges in order to qualify for an incentive under the Medicare EHR Incentive Program. Like Medicaid, they can't be hospital-based and they have to be living and they also have to be enrolled in our – the CMS PECOS system.

PECOS System—Provider Enrollment Chain and Ownership System. This is how we enroll Medicare providers. This is how – we also use this to pay Medicare providers, so they actually have to have an active enrollment in this PECOS system.

A Medicare provider does in order to – Medicare eligible professional does in order to receive incentive payments. So, let's go to next slide. So, slide nine is hospital eligibility, Medicare-based.

I thought we skipped that one already. All right. So, skip slide nine.

Slide ten brings us to the incentive payments. How much are the incentives? Here is where the rubber meets the road.

So, just to talk about the nitty-gritty here, incentive payment doesn't indicate it under the Medicare EHR Incentive Program. Again, they're based upon the Part B Fee-For-Service allowed charges. The most that an eligible professional participating in Medicare EHR Incentive Program can receive is \$44,000 for across five years of participation.

This is versus \$63,750 for an EP who decides to participate under the Medicaid EHR Incentive Program across six years. I'll also mention that there is, in addition to that \$44,000 batch loan that a Medicare EP could potentially receive if they are working in a health professional shortage area. They can potentially receive a 10 percent bump on top of the \$44,000.

So, here's the first thing to weigh, you know, if you could qualify for either if you have a Medicaid patient following. \$63,750 of the Medicaid versus \$44,000 under the Medicare incentive program. Again, Medicare you can participate for five years versus six years under Medicaid. But something else to recall is that in order to receive the maximum incentive under Medicare, you would actually need to start participating by this year.

After 2012, an eligible professional under Medicare who up against participating, say, in 2013 or later, they actually receive a lower overall incentive payment. And part of this is the fact that the Medicare Incentive Program only goes from 2011 to 2016, whereas the Medicaid EHR Incentive Program grows from 2011 to 2021. So, whereas the Medicare EHR Incentive Program is being phased out after 2016 under Medicaid, a provider could just be coming in for their first year of attestation and could go on through 2021 to receive the whole \$63,750. So, also consider the lifespan of this program.

You can only receive one incentive payment per year. First of all, this goes back to a couple of things. So, one is you cannot participate as an eligible professional under both the Medicare and the Medicaid EHR Incentive Programs.

Also, on the Medicaid EHR Incentive Program, we're going to talk in a minute, states that – whereas the Medicare Incentive Program was administered centered by CMS, states administered the Medicaid EHR Incentive Program. You cannot receive more than one Medicaid EHR incentive payment in one year. What I'm trying to say is you can't receive from multiple states, how about that?

Let's see here. And, finally, under the Medicare EHR Incentive Program, you have to demonstrate Meaningful Use of certified EHR technology for all five years. This is something else that Rob will discuss briefly.

Whereas under Medicaid, we're – and we'll talk about this momentarily – you can actually receive your first year incentive just for acquiring, just for adopting what we call adopt, implement, and upgrading certified EHR – certified EHR technology. You don't have to be actually using it.

You just have to have acquired it and you can actually receive your biggest Medicaid payment just for that first year for AIU, for what we call adopt, implement and upgrade. Then, for years two through six on the Medicaid side, providers do similarly to Medicare- have to demonstrate Meaningful Use. OK, the requirements for adopt, implement, and upgrade, we're just talking about this.

So, again, Medicaid EPs can receive their first year incentive payment just for this crossing, this very low hurdle of adopt, implement, upgrade of essentially acquiring access to certified EHR technology. So, adopt and, again, just essentially acquiring the access, this doesn't mean that you have to purchase EHR. You do have to be able to demonstrate like a financial or legal obligation to it.

So, there are even three EHRs, Web-based EHRs such as practice fusion promotes that – again, it's Web-based. There are no boxes or wires. But you do have to sign an end-user license agreement saying that you will use it. That you will comply with the requirements for using it. So, again, you have to demonstrate, even if you're not purchasing EHR, some sort of a financial or legal obligation to that EHR. And that's – that – they will now know that you're serious about adopting, implementing, or upgrading.

Implementing just means when you begin to – well, implement the certified EHR, whether you're training staff on it, whether you're loading patient demographics on it. You don't have to be using it for Meaningful Use or for health information exchange.

But, you know, just starting to incorporate into your work load – which can be quite a barrier, you know, by itself. Upgrading, you may have an EHR right now that does not meet the certification standards promoted by our sister agency, the Office of the National Coordinator for Health I.T.

So, they have these standards for certified EHRs, in which certified EHRs have to be able to partake and meet – in exchanging – health information exchange. You have to be able to meet the Meaningful Use criteria. And so, there are certified EHRs that ONC contractors have certified based on ONC standards that allow – that say these EHRs are certified.

So, you could upgrade if you have a noncertified EHR and you can add a certified module to it and then it becomes a certified EHR. So that makes sense. They could upgrade a currently noncertified EHR, is what I'm trying to say.

OK, so, that is slide 12. So, Meaningful Use. So, I'll switch over to Rob Anthony.

Robert Anthony: Thanks, John. I'm going to do a brief overview about Meaningful Use. Obviously, there are a lot of objectives and moving parts to Meaningful Use and I encourage everybody to take a look at our Web site, which is [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms). Make sure you put the s on the end.

But switching to slide 14, you will see our famous arrow slide. If anybody has ever seen our presentations before, we have this arrow slide and all of it to show what the path of Meaningful Use sort of looks like.

We conceive Meaningful Use as a three-stage process. It's sort of an escalator approach where the first stage and, you know, that's where the circle is and that's where everybody begins at stage one. The focus is on data capture and sharing.

So, you will notice that a lot of the objectives focus on recording and getting information into an EHR, implementing an EHR into your practice, and implementing it into your workflow. As we move forward into stage two, we

have a notice a proposed rulemaking out for stage two now. Those objectives focused a little higher on more advanced clinical processes.

And eventually with stage three, we hope to focus on really improving outcomes both for practices or – rather both for providers and for patients and the entire idea of Meaningful Use is to get you providers to use the certified EHR technology in a meaningful way that will impact patient care and improve outcomes. So, slide 15, just a very basic overview of what the requirements are for stage one Meaningful Use. Everybody starts in stage one, as I said, even though there are three stages.

Everybody starts at the bottom. The first step on the escalator, they always start at stage one. It doesn't matter what year you begin.

Your Meaningful Use and you're always going to begin on that first step and your first year of Meaningful Use. So, that will be your first year in Medicare or it could be your second year in Medicaid. It's always going to be a 90-day reporting period.

So, essentially, you're going to meaningfully use your EHR for 90 continuous days during that reporting year and then you're going to attest to that information for us. After that, you will begin using your certified EHR on a continual basis and you will report for an entire year. So, you actually will report through attestation and what you will report to us on is that you achieved certain thresholds and measures that we specified for Meaningful Use.

There are Meaningful Use objectives and there are Clinical Quality Measures. The Meaningful Use objectives have particular measures and thresholds that you have to hit. So, for example, there is e-prescribing.

You have to – 40 percent of the prescriptions that you write have to be electronically prescribed during the reporting period. There are some that are simply yes/no questions. For example, implementing drug-drug and drug allergy checks.

That's simply – simply, that functionality of your EHR has to be implemented for the entire reporting period. We also have Clinical Quality Measures. These are measures that are reported directly out of your certified EHR.

Unlike the other Meaningful Use objectives, there aren't particular thresholds that you hit on these. But they're information that you're going to report to us. And each of those Clinical Quality Measures has a separate numerator, denominator and exclusion that is unique to its population.

As I said, the reporting can be yes or no or a numerator/denominator. If all of this seems a little confusing to you right now because you don't understand how that will be entered, we're going to go over some of those attestation screenshots at the end of this call and you will see a little bit more of what we mean. The thing that I always like to tell people is that there are different thresholds for every measure.

But one of the things that you have to keep in mind is that in stage one, there are certain measures that are 80 percent and it applies to all of the patients that you see during that EHR reporting period. And that basically means that you're going to have to have 80 percent of those patient records. And these are patients that you see during the reporting period.

That has to be maintained in the certified EHR technology. So, at a base, you're going to have 80 percent of the patients you see in your EHR in stage one. Moving on to slide 16, this gives you a – sort of a basic overview of what you're going to have to meet as far as Meaningful Use.

This is the structure and we call it a core menu structure. So, for eligible professionals, there are 15 core objectives that everybody has to report on. And by core, we mean that everybody is going to have to do those as opposed to menu objectives.

There are 10 of those menu objectives provided. An eligible professional would select five of those menu objectives to report on. So, you will report on 15 core objectives and five out of ten menu objectives.

Now, the important thing to keep in mind about those menu objectives is that we recognize that not all of those objectives may apply to everybody's scope of work. So, for certain of those objectives, there are exclusions provided. For example, e-prescribing, which we were describing earlier. There is an exclusion provided for any provider who prescribes less than 100 medications during the reporting period.

They can be excluded from reporting on that particular objective and that exclusion won't count against them. They will still be able to meet Meaningful Use and receive an incentive payment. As I said, you're also going to have to report on Clinical Quality Measures and eligible professionals are going to have to report on a total of six or nine Clinical Quality Measures.

There are three core Clinical Quality Measures that everybody has to report on. If one or all of those core Clinical Quality Measures are not applicable to your scope of practice, you would select from three alternate core Clinical Quality Measures. And then, finally, there is a menu set of Clinical Quality Measures of 38.

You would select three of those that are applicable to your practice. If there are no particular Clinical Quality Measures that are applicable to your scope of practice, you can select any three out of that list and you just end up reporting zeros out of your EHR. Hospitals have a similar structure to this, by the way.

They have a core and menu. There is an overlap between a lot of the objectives that you would see in a hospital's set of menu measures and core measures. They aren't exact.

There are some differences. And the reason that I like to explain this is because there are going to be eligible professionals who will practice in both a hospital setting and also within a practice setting, an ambulatory setting. But if you're an EP, you have to achieve Meaningful Use using an ambulatory certified EHR.

You can't use the hospital's inpatient or emergency department EHR in order to achieve Meaningful Use. And that's because, as you see, there are some differences between the core and the menu objectives. On page 17, I'm not going to go through each of the individual objectives that you have to meet.

As I said, there is that core and menu structure. I would encourage you to take a look at what we have on our Web site and what we have on our Meaningful Use specification sheets. At left, you can see this is an example of a table of contents for EPs of the core and menu set objectives.

If you visit our Web site and, again, there is the Web site there on the right, the cms.gov Web site. If you click on the Meaningful Use overview tab and scroll to the bottom, you will find that there is a section for eligible professional Meaningful Use specification sheets.

And each of those sheets covers a particular objective core menu that an EP has to meet. It will give you the objective, the measure that you actually have to meet, any exclusion information. It will define particular terms that crop up in either the objective or the measure that are important.

It will actually give you the numerator and the denominator that you're going to have to report on. So, for example, in the example that we've been using of e-prescribing, the denominator is all the – you need all the prescriptions written during that EHR reporting period. The numerators are the prescriptions that are actually electronically prescribed.

So, it's going to break down numerator and denominator like that for you. And show you exactly what you have to report for attestation. And then, it's going to have some basic information that is crucial for you to know for just meeting the objectives.

So, I encourage everybody to use those Meaningful Use specifications, so you can take a look at them. It's going to give you a lot of information about how to get to Meaningful Use. Number 18, as I said, there are exclusions for a number of these Meaningful Use objectives.

The exclusions are not – they don't count against you for actually meeting Meaningful Use. So, if you claim an exclusion, you can still receive an incentive payment. It is technically possible for you to claim an exclusion to a menu measure if there are other menu measures you can hit.

We encourage people, obviously, to take advantage of reporting on those measures that they are able to report on and using a certified EHR in a meaningful way that will impact patient care. But we do recognize that there are going to be certain menu measures that, although you may have a population or they may be somewhat outside the scope of your practice. So, it is possible to do that.

But there are, you can see in these Meaningful Use specification sheets, exclusions for things like performing or reporting to an immunization registry or e-prescribing, or so on. For slide 19, we often get a question especially in this day and age for eligible professionals who practice in multiple practice locations. What if some of my practice locations don't have a certified EHR?

Well, we did account for that when we put the program together and we do have a threshold that you have to hit. And the threshold is that 50 percent of your total patient encounters have to be at locations where you can use that certified EHR technology. So, 50 percent of the patient encounters in a place where you can actually demonstrate this Meaningful Use.

And if you were able to hit that 50 percent threshold, then you will essentially base all of your calculations on just those patient encounters in places where you have certified EHR. So, if you have 51 percent of your patient encounters in places where there is a certified EHR, then your denominator will essentially be 51 percent of those patient encounters.

On slide 20, Clinical Quality Measures. In 2011, everybody attested through the Web attestation, and we'll show what that looks like, to Clinical Quality Measure data. You basically reported that data by entering numerator, denominator, and exclusion information into our Web module. That option is still open in 2012.

But there are also options for electronic reporting, and we are testing some electronic reporting pilots right now. We won't go into a lot of detail here. But there is information that is available on our Web site.

I encourage everybody to visit the Web site and click on that Clinical Quality Measures tab for more information. There is a pilot program available for eligible professionals. There is also a pilot program that is available for eligible hospitals to take a look at.

So, on slide 21, just to sum up, as you look at the Medicare and Medicaid programs, obviously the Medicare program is implemented directly by CMS. Medicaid is voluntary for states to implement. But at this point, we have 43 states that are implemented, and we do expect the remainder of the states to be online in 2012. There are no Medicaid payment reductions or adjustments.

But if you are a Medicare eligible professional, you are going to be subject to a payment adjustment if you don't become a Meaningful User. And that payment adjustment will begin in 2015. We'll have more details about that on our Web site.

Right now, some of the details about how that payment adjustment will be applied are in a notice of proposal we're making that we have available now. As I said, with Medicare, you're going to demonstrate Meaningful Use in your first year. And as John covered with Medicaid in your first year, you have an option for an adopt, implement, and upgrade payment.

You would then demonstrate Meaningful Use in your second year. The incentives are larger on the Medicaid side. So, if you have the possibility of participating in one program or the other, if you can meet those patient volume requirements on the Medicaid side and you are an eligible professional by definition on that side, it does behoove you to participate in the Medicaid program because the maximum incentives over there are \$63,750 as compared to \$44,000 for EPs on the Medicare side.

There is a bonus on the Medicare side for eligible professionals in health professional shortage areas. That's not available on the Medicaid side. It amounts to 10 percent.

It's \$4,400 over the life of the program. We do include this because it is in our regulation, but I do want to give a caveat here. The way you meet Meaningful Use is the same for Medicare as it is for Medicaid.

So, everybody needs those core and menu. Everybody reports on those Clinical Quality Measures whether you're participating in Medicare or Medicaid. There is a provision within regulation that states can require or implement an extra requirement for Meaningful Use.

At this point, no state has exercised that option. So, right now, it's identical. The way that you're going to demonstrate Meaningful Use is identical between Medicare and Medicaid.

And then, of course, as John covered, the last year that a provider can really initiate the EHR Incentive Program on a Medicare side and receive an incentive payment is 2014. I do want to clarify that although we don't pay any incentives to EPs after 2016 on the Medicare side, that does not mean that the program ends. The program still continues to go, and if you don't continue to participate in the program and are not a Meaningful User, you could be subject to penalty adjustments.

On the Medicaid side, there is a lot more flexibility. It is not – doesn't have to be continuous years. The last year that you can initiate into the program or receive an incentive payment is 2016.

But you do have a lot more flexibility about the spacing of those years because they don't have to be continuous in Medicaid. So, again, if you can qualify for both programs, you really want to take a look at the Medicaid side because of the flexibility and the higher amounts. And I'm going to turn it back over to John to show a little bit of overview of what the registrations look like.

John Allison: Thanks, Rob. Right. We will take a very high-level view of registration.

I just want to remind everybody that if you go to the CMS EHR Incentive Programs Web site, via the registration tab, and we have very good and very well-developed and very intuitive registration user guides, both for Medicare EHR Incentive Program participation and Medicaid EHR Incentive Program participation. So, just recall that we have some very excellent documents to guide people through the registration process. There is also a Webinar, I believe, as – for registration.

So, that is all available at the EHR Incentive Program Web site on the registration tab. A couple other things I just want to dive into. For both Medicare and Medicaid providers, you have to have your national provider identifier, your NPI, in order to register.

And if you're a Medicare eligible professional, you also, again, have to have that active enrollment in PECOS, in our Provider Enrollment, Chain, and Ownership System. You don't have to on the Medicaid side but you do on the Medicare side. Also, everything – we're going to do some screenshots in just a moment of the CMS registration and attestation system.

So, very high-level screenshots. Everything that a provider who is attesting under the Medicare EHR Incentive Program, that's all going to be done under the registration and the attestation process will be done under the CMS registration and attestation system. But as we'll see in a minute, for Medicaid, it's a little different since the states actually administer their own Medicaid EHR Incentive Programs within CMS guidance and using federal funding.

You actually will register – a Medicaid provider will register at the CMS registration and attestation system. But then, after their registration is successful, they will go to their state EHR Incentive Program portal to verify eligibility and to complete attestation. So, we'll talk a little bit about that also.

So, looking at slide 23 – well, actually, I guess, I touched on a lot of this already. Again, so, for states with launch programs, right now, as Rob mentioned, we have 43 states that have access to Medicaid EHR Incentive

Programs. Medicaid providers would go to the CMS EHR registration and attestation system to register.

Then, what a Medicaid provider would view after they receive something back, we will see that the screenshot of the chain of registration is successful. They will also receive an e-mail back saying registration is successful. They would wait about 24 hours and then go to their state Medicaid EHR Incentive Program portal to complete their eligibility and verification.

And if they're ready to do so, to attest. And we ask for about 24 hours because what we do, we send the states files nightly, after the providers register after Medicaid providers register with the CMS registration attestation system. And we send the states files.

And so, you know, the day after that you register as a Medicaid provider with CMS, you should be able to go to your state EHR Incentive Program portal and verify the eligibility information that will pop up, that has been taken from the CMS to registration and attestation system. And, again, if you're ready at that point, you can go ahead and attest. Something else we see here.

States are obligated from the time they launch their incentive programs and start accepting registrations. They are obligated to issue an incentive payment within five months. All the states right now are meeting that.

Actually, of the 43 states with active incentive programs right now, 41 have already dispersed incentive payments and the two that haven't is first incentive payments just launched in January. So, states are meeting those obligations. Something else I just wanted to mention quickly about the CMS system, if you are a provider and you have an office manager or someone who you would like to delegate the registration and attestation process to, we have a system, the CMS identity and access management system – we've also called the IAM system, which will allow you to delegate your ability to register and attest for the program and also spend through someone else. And so, that's a CMS capability in our registration and attestation system. States don't always have the same capability.

So, even if you – even if you have your office manager register your – registered you for a Medicaid – for the Medicaid EHR Incentive Program in the CMS registration and attestation system, you might as well have to go in at the state level to do your own attestation to your state’s Medicaid EHR Incentive Program. So, it varies by state. Make sure you check with your state.

So, moving on, OK, this, I’m on slide 24, this actually brings us to the slides that are really just screenshots of our registration and attestation system. What this slide shows you is in the lower lefthand corner that you have to be sure you have your NPI username and password for the login for the system. Now, this one, you’re just logging in.

You’re not yet, you know, deciding which program, Medicare or Medicaid that you’re registering in. You just demonstrate essentially access to the system. You will also see, speaking of allowing a surrogate to register and attest for you, there is, in the upper righthand side of that screenshot, a “create a login” hyperlink, and EPs, again, can click on this link to authorize a surrogate like to get an office manager or practice manager, to register on their behalf.

So, that is, you can find that capability right there on the login instructions to make it. So, let’s jump to slide 25. So, this is a – just a welcome screen. It shows you the four tabs that you would navigate to navigate through the processes as a registration tab, an attestation tab, a status tab. Again, it says here on the slide.

Tabs will guide users through each stage. So, that’s pretty basic. So, that is slide 25. So, move on to slide 26, here are the actual registration instructions.

So, you will see if you’re looking at the bottom, on the far right, you will see “action.” And in that “action” column, you’re going to see a button that says “register.” So, again, on the right there, towards the bottom, you would click on this button in order to continue this registration process.

But you will see under the registration instructions that there are various other things you can do from this page if you are already registered but you want to modify your registration. Let's say you want to switch between the Medicare EHR Incentive Program and the Medicaid EHR Incentive Program. You – you've only received one payment, it's still before 2015, you could actually switch from Medicare to Medicaid.

You can do that from this page. You would have to, again, click on "modify." But that will allow them to initiate the process to switch from Medicare to Medicaid.

You can also – as you can see on this page, you can cancel your registration, you can reactivate, free to cancel registration and so on. So, this registration home page is very important. So, moving on to slide 27, this is also under the registration tab.

And here's where you actually would select between the Medicare and Medicaid EHR Incentive Programs. So, and then, right under that, you actually select your eligible professional type. And, again, this dropdown lists the types of eligible professionals would be determined by whether or not you pick the Medicare or the Medicaid EHR Incentive Program.

And if you pick the Medicare EHR Incentive Program, you also receive it from to where there will be a dropdown list of states who've launched active programs. And you, at that point, also select your state that you want to participate under – for Medicaid EHR Incentive Program. This slide also has – it has a question that says, "Do you have a certified EHR?"

So, here's where we ask you about that. But you actually – to complete the registration, you don't actually need to have a certified EHR. However, if it still says "no" there, by the time you come back to attest then it will prevent you from successfully attesting, to meeting program requirements and getting incentive payments.

So, again, in order to complete registration, you don't have to have a certified EHR. So, if you leave that "no," that question mark no. But you will have to

mark it yes in order to come back and attest, again, presumably – you actually do it at certified EHR at that point.

Then, there is another box at the bottom, the EHR certification number. So, when you have a certified EHR, you're going to need to enter the EHR certification number that you will get from our sister agency, the Office of the National Coordinator. It has a certified health IT product.

This is all the complete EHRs, all the EHR margins that are certified. So, once you have selected your EHR or you have aggregated enough EHR modules, so that it's considered a certified EHR, you will receive an EHR certification number.

That is what is being asked at this point. So, again, you would have to go to that or with that Office of the National Coordinator certified health IT product list in order to do that. So, that is slide, pretty much all for slide 27.

So, slide 28, OK, well, this shows submission receipts. So, OK, you've entered your registration information and you reviewed, and you're attesting. After seeing it and you click submit registration, so, what will happen is then there will be a claim that pops up asking if all the information you provided is true, accurate, and yada yada. You agree to that.

And then, after you have submitted, after you've clicked, you know, register, then you will receive this submission receipt, which just verifies you successfully completed your registration. You will print your receipt.

You see that button in the lower lefthand corner. So, you will print – you'll click that print button and after you do that, you will actually receive an e-mail notification of your registration complete with your registration ID, which is something you are going to want to hang on to if you have any questions about the registration. So, that is slide 28.

So, moving on to slide 29. OK, so, this is actually a screenshot from the Michigan Medicaid EHR Incentive Program attestation portal. As we've mentioned, once – if you're a Medicaid provider, you're not finished once you

have completed registration through the CMS registration and attestation system. The system will prompt you that you will then need to go to your state's and Medicaid EHR Incentive Program portal.

So, you go to that about 24 hours after having successfully completed registration through CMS and what will happen, as this particular slide shows, CMS is going to send your registration information to the state Medicaid agency that you choose. And so, here's what comes up, here's what an eligible professional who's logging in to the Michigan Medicaid incentive portal is going to see. You would want to verify that this information is correct.

Again, this information was taken from your CMS registrations. So, if anybody is wrong, if you're (inaudible) or on that you would actually have to go back and change it in the CMS registration and attestation system. So, this is what it's going to look like and this is just the information page.

After you have verified that information is correct, you would click – in the example of this Michigan Medicaid portal on eligibility and these other screens just show you – this is specific to Michigan Medicaid. But similar processes that you'll have to go through at each state Medicaid EHR Incentive Program portal. For example, slide 30 shows, under eligibility, there has to be reporting period during 90-day period in which you are verifying that you have met Medicaid – that you have to check Medicaid patient volume or that you have to check each individual patient volume to verify that here in the state system. It would go.

In this case, you ask other questions about your pediatrician. And so, that's just an example of what the state's eligibility page would look like.

Slide 31 is also a state page. And, again, this just shows you the attestation process once you are completing it. You would hit register. So, those three slides are just examples from Michigan of what the state eligibility verification and attestation process would look like.

So, now, for Medicare EHR Incentive Program attestation, I'll hand it back over to Rob.

Robert Anthony: It's the same system for Medicare where you register. And, again, you go to our Web site [www.cms.gov/ehrincentiveprograms](http://www.cms.gov/ehrincentiveprograms).

You click on either the registration or attestation tab on the left and you will see a link that will take you in to the system. You will go back to the same place that you registered for Medicare to attest for Medicare. Obviously, when you attest for Meaningful Use for states, you're going to go through the state's Web site to finish that.

So, what – the screens we're about to see are for Medicare attestation. And we'd like to show people these because they give you a good sense of what it is you're actually going to have to enter. So, we'll show you some examples of some numerator and denominator screens, yes or no screens, and how you will select things.

And we'll go through these pretty fast. But it will give you a good idea of what you're looking for. As there are registration user guides on the Web site, there are also attestation user guides. They are under the attestation tab. There is one for both EPs and for eligible hospitals. Please download those.

Take a look at it. They will walk you through every screen, step by step, tell you what information you need to have on hand, what button you have to push, and give you some helpful hints in case there are areas where you get stuck. So, please take a look at those. Those are downloadable under the attestation tab.

If you go to 33, you will see that when you log back in to the system. You will be able to go to the attestation tab. You will see a section that is similar to what you saw under registration.

Your name will come up as an EP. In this case, you're John Doe and there will be a button there, because you have not done anything, that will say "attest" and that will take you immediately into the next screen. And you will

see a series of screens that will walk you step by step through each core measure that you have to do.

It will walk you to the menu section where you will select from where – which menu – which menu objectives you want to report on and the same with Clinical Quality Measures, and we'll show you a sample of some of those screens. So, slide 34 shows you an example of the yes and no type of questions we would ask. So, here is our drug-drug and drug allergy interaction check alert question that we talked about before.

So, the measure here is that you've enabled that functionality for the entire EHR reporting period, and we literally ask you, have you enabled that functionality for the entire EHR reporting period? You click yes or no on this box. And then, you hit save and continue.

A couple of things that I want to draw attention to on this screen, there is an area here for additional information, and it gives you a link for Meaningful Use measure specification page. These are the Meaningful Use specification sheets that we showed earlier. Every single one of these core and menu measures has a direct link to the specification sheet within the module.

So, if you have some questions about what exactly goes in here, you can click that hyperlink and it will take you to the PDF of that specification sheet where you can get more information. The other area that I want to draw your attention to – at the bottom right of the screen, there is a “save and continue” button. That can move you on to the next measure.

But more importantly, every time you click that “save and continue” button, your progress through the entire module is going to be saved, which means that you don't have to do attestation at one fell blow. Registration is relatively straightforward and most people can complete that in about 10 or 15 minutes. But attestation may take you some time, depending upon what materials you need and what you need to gather together.

So, once you hit save and continue, if you leave after that, you can always come back to the attestation module and finish your attestation. So, page 35,

we'll show you an example of a numerator/denominator question. In this case, it is a problem list of current and active diagnoses, the measure is put down here.

It's more than 80 percent of all unique patients having an entry. We show you exactly what the numerator is. We show you exactly what the denominator is so denominator here a number of unique patients seen during the EHR reporting period.

And then, you literally get a box for numerator and denominator, in which you would enter values for those numerator and denominators. Most people are going to get those off of the reports from their certified EHR technology. In some cases, where you have some of those patients that you've seen during the reporting period have records within the EHR but others don't.

Maybe you're still transitioning from paper to electronic, but you have done 80 percent of those patients. You might have to add together some of your – what's in your EHR and what you have in paper records.

So, you hit “save and continue” and you move on. On 36, we talked about some of these objectives having exclusions. So, in this case, this is – harkening back to our e-prescribing objective where we talked about the exclusion, being an EP who writes fewer than 100 prescriptions during that EHR reporting period, and we literally ask you in that case: Do you meet the measure of that exclusion? Does this exclusion apply to you? If you hit “yes,” you just could – it's just going to move you on to the next measure.

You will never even see the rest of it. If you hit “no,” then you're going to see that numerator and denominator section and you will have to fill that out. The next slide shows you an overview of what you'll see when you have to select menu measures.

There are some restrictions on how you do menu measures, and those are described within the actual menu measure screen. You could also find descriptions of that on our Web site. But you would literally select your menu

measures by putting a check mark in the box for those menu measures that you're going to report on.

And then, when you go to report on those menu measures when you hit the "save and continue" button, it will literally take you to the next screen, and it will walk you through just the menu measures that you have selected to report on. So, slide 38 – unfortunately, this is an older version of one of the screens. But this was one of the menu measures for generating a list of patients, and it's a yes/no question. And you will see that they look exactly like the core objectives screen. They're yes/no or numerator or denominator measures.

On the next slide, you will see the Clinical Quality Measures. We talked about there is the possibility of using the EHR incentive pilots for electronic reporting of Clinical Quality Measures in 2012. When you get to the Clinical Quality Measure section, it's going to ask you, "are you planning to participate in that pilot?"

If you are planning to participate in that pilot, you would indicate yes. And then, you would go ahead and you would follow the instructions for uploading your electronic Clinical Quality Measures through that way. And there is a link here at the bottom of the page for Clinical Quality Measures specification page that will give you some more information about that pilot.

If you select no, you're going to enter the data for your Clinical Quality Measures the same way that you enter your data for the core and menu objectives. And we have some sample screen shots of that. So, the next one you will see, this is the example of one of the core Clinical Quality Measures that everybody has to report on: hypertension, blood pressure management.

It gives a description of it. You can click on the link for the Clinical Quality Measure specification page to get more information about that particular Clinical Quality Measure. The one thing that I do want to draw people's attention to when you go through the Web site, if you will look at core and menu objectives, you're going to see the numerator field before the denominator field. If you enter your Clinical Quality Measures through the Web attestation rather than through the electronic reporting pilot, those fields

are reversed. You're going to see the denominator before the numerator. And that's because of how the Clinical Quality Measures are e-specified. But just be aware of that. You don't want to transpose those two numbers.

On the next slide, you will see that some of the Clinical Quality Measures have multiple fields or multiple measures. This is an example of one of them for preventative care and screening for tobacco use. It's in the first part of that measure, which has a separate denominator and numerator.

Tobacco cessation has a separate measure forth with a separate denominator and numerator. As we said before, you're going to report your Clinical Quality Measures directly out of your certified EHR. So, you literally will generate a report out of your certified EHR.

And then, you will transcribe those numbers from the report into this attestation module. So, if you have an – a denominator and numerator for this, that's going to come up on the report and on those Clinical Quality Measures, whether multiple measures or multiple fields, that's going to come up for you. The next page shows an example where you have not separate measures for Clinical Quality Measure but where you have different population criteria.

These again are individual of the Clinical Quality Measure. But the report that you generate out of your certified EHR is going to have those different fields there and you'll literally transcribe those numbers. Slide 43 will show you the additional Clinical Quality Measures.

Again, if you're an EP, you're going to select three out of this list of 38. You're going to select these in exactly the same way that you select your menu measures. You're going to put a checkmark in the box that you want to report on and it will bring up the three Clinical Quality Measures that you've chosen and then you'll go ahead and answer the data for those quality measures.

Slide 44 will show you what happens when you actually submit. You'll go through. You'll have a chance to edit your information at the end or verify it

at the end. And then you will go through a series of screens where you legally attest and you submit your information. You will find out immediately whether you have met the thresholds of the Meaningful Use measures.

If you didn't meet those thresholds, you will get a screen like this, and it will say "rejected attestation." And it will tell you why you were rejected. In this case, it's because one or more of the Meaningful Use core measures and one or more of the Meaningful Use menu measures didn't meet the particular threshold.

If you're successful, you will see a different screen, which will say "Successful submission. Congratulations." And as long as there are no other issues, you will receive a payment from us.

If there are problems, you will see in slide 45, you will have an opportunity to see what those problems are. You'll be able to click on an attestation summary and you'll be able to see on the left the objective; in the center column, the measure that you were supposed to meet; and in the entered column, the values that you actually put into the attestation module.

It's useful to be able to look at this because as you go through, we all make mistakes typing, and you may discover that you transposed some numbers or maybe you hit some things accidentally. And that's what caused your attestation to fail. If that's the case, you can go through and you can edit that particular objective measure information and you can resubmit your attestation immediately and see if you are able to meet Meaningful Use.

So, that's a very high-level overview of attestation. As I said, there are user guides on our Web site and some more detailed walkthrough and detail about the particular Meaningful Use objective. So, John is going to point you to some of those in resources and I urge everybody to go to our Web site.

John Allison: Yes. Thanks, Rob. OK, so resources, Rob and I have already actually been discussing pretty extensively a lot of the resources that are available right now at the CMS EHR Incentive Program Web site, which is itself a very, very good resource.

So, we're going to guide you to some of these – to some of the Web sites, as well as, I believe, some helpdesks that can help you as you go down the path of registering and attesting for either Medicare or Medicaid EHR incentive payments. Something that we have that showed up fairly recently that's a very good tool is there is an introductory guide to the Medicare EHR Incentive Program for eligible professionals.

It's very, very comprehensive. It actually covers a lot of the information that we've already gone over in this presentation. It covers eligibility. It covers Meaningful Use. It covers registration, even attestation to an extent. It doesn't necessarily have the screenshots that we've seen in this presentation. But it is a very comprehensive, very handy guide.

Right now, we were also developing the Medicaid equivalent of it, which will be an introduction to the Medicaid EHR Incentive Program for Eligible Professionals. Again, it will become – be comprehensive, covering eligibility, registration, and all that stuff. And we are anticipating that it will be available on the CMS EHR Incentive Program Web site come mid-April or so.

So, be on the lookout for that. On our EHR Incentive Program Web site, we have FAQs; we have an overview of stage one of Meaningful Use, what we've been talking about here, as well as a link. Rob indicated the proposed rule for stage two.

There is a link and I believe an overview of that also that you can find on our EHR Incentive Program Web site. There is a listserv that you can join and receive regular e-mails. You can also follow us on Twitter.

You can – from our CMS EHR Incentive Program Web site, you can check the spotlight and upcoming events tab, which will have other calls, I believe, other provider calls, as well as meetings and other events going on. We also wanted to give you the Web site for the Office of the National Coordinator's certified health IT product list, which we have mentioned, where you could find your EHR system or your EHR module to find if it is certified and what that certification number is for whenever you are coming back to attest.

We have – on slide 48, it’s our troubleshooting guide. There is an EHR information center helpdesk, which we have the hours and phone number available here. There is the NPPES helpdesk, whereas you need – you’re having trouble registering with your NPI or your NPPES user ID and password. And you can call this helpdesk.

We have the phone number for the PECOS helpdesk. So, if you need to find out if you have an active PECOS enrollment as a Medicare eligible professional, you can call that number. And there is more information about our identification and authentication system, which, again, if you are going to have a surrogate registrant attest for you and office manager in your practice.

There – then, on slide 49, these are the user guides that Rob and I mentioned. The registration user guide for EPs, for Medicare, the same for Medicaid. The next slide, slide 50, you have the attestation user guide, as well as the EHR information helpdesk numbered hours again.

And that now brings us to Q&A.

Diane Maupai: Well, thank you so much, John and Rob for that wealth of information. I know you’re all anxious to get to the question and answer session. But before we do, we’re going to pause just for a few minutes to complete quick keypad polling, so that CMS has an accurate count of the number of participants on the line with us today.

There may be moments of silence while we tabulate the results. Holley, we’re ready to start polling.

## **Polling**

Operator: CMS greatly appreciates that many of you minimize the government’s teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance to better document how many members of the provider community are receiving this valuable information. At this time, please use your telephone keypad and enter the number of participants that are currently listening in.

If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Again, if you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

Please hold while we complete the polling. Please continue to hold while we complete the polling.

Diane Maupai: While we're holding, let me take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get as many questions in as we can, please limit yourself to one question.

Holley, when you're ready, we're ready to take the first question. Let me add that we've also been joined today by Maria Michaels from our Office of Clinical Standards and Quality, who is our Clinical Quality Measures expert. She's going to be available to answer any questions you might have about that.

## **Question and Answer Session**

Operator: Thank you. We will now move in to the Q&A session for this call. To ask a question, please press star followed by the number one on your touchtone 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 your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Please hold while we compile the Q&A roster. And your first question comes from the line of Joe Harrington.

Joe Harrington: Hi. This is Joe Harrington with Dabbs, and I have a two-part question as it relates to the penalties. First of all, we have providers who practice under managed care, Medicare HMO type program, which they don't have Part B claims. Do they qualify for the incentive if most of their claims were under the managed care Medicare program?

And the second one is for – second part of the question is for NPs who don't have enough – don't have the 30 percent payer mix for Medicaid. If they don't purchase the MR or participate in the program, are they still penalized at the end of the phasing period?

Robert Anthony: So, the answer to the first question is that those EPs are eligible, but they're eligible through the Medicare Advantage organization for payment. So, they – if they don't have any Part B claims, then they're not going to fall under Medicare. They're going to get paid through that organization, the Medicare Advantage organization.

The answer to the second part is that there aren't penalties; there aren't payment adjustments on the Medicaid side. So, if they are not eligible for Medicare, then – and nurse practitioners are not – then, they're not going to be subject to a payment adjustment.

Operator: And your next question comes from the line of Kimberly Franks.

Kimberly Franks: Hi, this is Kimberly Franks with AmSurg. I'm referring to slide 19, and probably my question needs to go to Rob Anthony. We represent many Ambulatory Surgery Centers and have had an issue with this on slide 19.

We have a lot of GI physicians specifically who see a lot of their patients in their practice. But they also get direct referral, so the patient comes directly to the surgery center where there is not certified EHR technology. So, in our example, a physician sees 100 percent of their patients in their practice in the certified EHR technology that they have initiated in their practice.

However, of the 100 percent of their patients, 60 percent of the patients that they see are only seen in an ASC that does not have certified EHR technology

because ASCs are not part of Meaningful Use and don't have any incentives to bring certified technology. Is that provider then unable to get Meaningful Use incentive dollars even though he has done his work to have – to bring Meaningful Use into his practice and he has absolutely no recourse in the ASC? Thanks for your time.

Robert Anthony: In the case that you're describing, if the provider is not seeing at least 50 percent of their total patient encounters at a location where there is certified EHR technology, then they're not going to be eligible for the incentive. So, if they are having 60 percent of their patient encounters in an ambulatory surgery center where there is not a certified EHR, then that – then they won't be able to participate as Meaningful Users.

Kimberly Franks: OK. Thank you, Rob.

Operator: And your next question comes from the line of (Tammy Arbuckle).

Benjamin Shaikun: Hello. My name is Benjamin Shaikun with First Urology in Jeffersonville, Indiana. I wanted to know if any of the stimulus funds, I think those were brought about as a result of the HITECH Act, but I wanted to know – are those at risk at all with the, you know, Supreme Court hearing with Obamacare?

Robert Anthony: You know, I absolutely knew that was going to come up. The HITECH Act is actually part of the American Recovery and Reinvestment Act. It is not part of the Affordable Care Act, which is the legislation that is currently being debated right now by our Supreme Court.

So, whatever ruling comes out of the Supreme Court actually won't affect HITECH funding at all.

Benjamin Shaikun: Thank you.

Robert Anthony: Sure.

Operator: And your next question comes from the line of Lisa Clark.

Lisa Clark: Hi. This is Lisa Clark at Anson County Health Department, North Carolina. Our – we have a nurse practitioner on staff, and she – her overseeing physician is a hospital-based physician.

Will my nurse practitioner be available to the funds under Medicaid?

John Allison: Yes. So, you said her overseeing physician is hospital-based but she is not hospital-based?

Lisa Clark: No. The nurse practitioner is not. She is employed –

John Allison: OK.

Lisa Clark: By the Health Department.

John Allison: OK, great. So, if 90 percent or more of her services are, you know, not provided in a hospital setting, then absolutely she can be eligible for the Medicaid EHR Incentive Program.

Lisa Clark: Alright.

John Allison: As long as she meets all of the other eligibility requirements.

Lisa Clark: Thank you.

John Allison: Sure.

Operator: And your next question comes from the line of Janice Pollock.

Janice Pollock: Yes. Janice Pollock, Carolina GI Associates, North Carolina. Our office is in the process of obtaining an EHR this year.

Am I correct that you stated we will be able to calculate the 90-day period via the previous year? So, that basically we can use any 90-day period from the previous year to show that we have the 30 percent per physician in our office?

John Allison: Right, right, right, right. OK. So, again, you're asking about the Medicaid EHR Incentive Program, that's correct.

You actually – you could choose the 90 – the continuous 90-day period in the previous calendar year. You get to choose, you know, a 90-day period that looks best for your Medicaid patient volume.

Janice Pollock: OK.

Robert Anthony: And just to clarify for folks, that's for calculation of Medicaid patient volume for your actual Meaningful Use 90-day period. That actually has to happen in the payment year that you're doing. So, if 2012 is what you're getting paid for, then your 90 days would have to be in 2012.

Janice Pollock: OK.

Diane Maupai: Thank you, Rob.

Operator: OK. And your next question comes from the line of David Blumenthal.

David Blumenthal: Yes. We met EMR in December 30th of 2011. We started the second year to meet Meaningful Use on January 2nd of 2012.

When will we be eligible to our second payment?

Robert Anthony: So, I'm sorry, to clarify, you actually attested last year in 2011 the 90 days?

David Blumenthal: Yes, on December 28th.

Robert Anthony: Excellent.

David Blumenthal: And then, we received the payment six weeks later.

Robert Anthony: Got you.

David Blumenthal: February. And we started the new Meaningful Use, started January 2nd of 2012. When can we submit for our second year?

Robert Anthony: So, essentially your second year – well, first of all, thank you for being one of the first people in 2011 and congratulations for receiving the incentive

payment. Secondly, your second year is going to be an entire year of Meaningful Use. So, you will have to wait until the conclusion of 2012.

And then, after the conclusion of the year, you will essentially have a two-month period basically until the last day of February to also attest again the way that you did before for this period for the entire year of Meaningful Use. And after you do that attestation, then you'll be able to receive incentive payment.

David Blumenthal: Is there anything different we have to do for the second year that we didn't do for the first year?

Robert Anthony: Well, other than that, longer reporting period. So, your first year you did 90 days, your second year is going to be the entire calendar year, 365 days. But, otherwise, it's just a longer reporting period with the exact same incentives and the exact same things that you have to report on.

David Blumenthal: Thank you very much.

Robert Anthony: Sure.

Diane Maupai: Thank you, Rob.

Operator: And your next question comes from the line of Marisa Maduro.

Marisa Maduro: Hi. My name is Marisa Maduro calling from VI Oral Surgery. We are a private practice, an oral and maxillofacial surgery office, and I would like to know if we qualify for the Medicaid incentive.

John Allison: OK. Hello. OK, so, as a practice – the practice can't actually qualify for an incentive.

It would be individual eligible professionals at the practice that can qualify for the incentive. Does that make sense? So, in other words, the doctors at the practice, whether MDs or DOs, as long as they're one of the qualified Medicaid EHR from eligible provider types that they would actually be the

ones you have to meet the eligibility criteria and who have to register and attest.

Does that make sense? So, you could have more than one doctor potentially at your practice that qualifies for a Medicaid EHR incentive payment. But the practice itself wouldn't qualify.

Marisa Maduro: OK. Because I saw something that says only the 50 states, and we are in the U.S. Virgin Islands.

John Allison: Oh, excuse me. Virgin Islands.

Marisa Maduro: Yes.

John Allison: I didn't hear – I missed that part. Right, right.

The U.S. Virgin Islands right now is underway with planning their Medicaid EHR incentive payment of EHR Incentive Program. But they have not launched it yet. And, unfortunately, you won't be able to participate in the program until the U.S. Virgin Islands actually launches its Medicaid EHR Incentive Program.

Marisa Maduro: And that's the same for both Medicare and Medicaid?

John Allison: In the territories, providers actually are not eligible for Medicare EHR incentive payments. They're only eligible for Medicaid EHR incentive payments.

Marisa Maduro: OK.

John Allison: OK?

Marisa Maduro: OK. Thank you.

John Allison: Sure.

Operator: And your next question comes from the line of Steven Ghareeb. Steven's question has been withdrawn. Your next question comes from the line of Grace Bi.

Grace Bi: Hi, this is Grace Bi from Health Care Association of HANYS. I just have a question regarding the Medicaid incentive payout timeframe. Slide 23, last bullet.

It says states will pay no later than five months after you register. So, I'm just wondering, is that a requirement for the state or it's just a simple statement of fact?

John Allison: No, it's a requirement for the state. It's in our self-regulatory guidance.

Grace Bi: OK.

John Allison: We just have the payment in.

Grace Bi: Is that also applicable to hospital payment?

John Allison: Yes, it is.

Grace Bi: OK. Thank you.

John Allison: Sure.

Operator: And your next question comes from the line of Jamie Wilkowski.

Diane Maupai: No, maybe not.

Operator: All right. Jamie's question has been withdrawn. Your next question comes from the line of Melonie Roberts.

Melonie Roberts: Hi. My question is regarding new practitioners beginning practice in 2012. Do you have – when you're basing your – to know if you make the Medicaid requirements of the 30 percent in the practice. Do you have to have a record from 2011 or can you go from the first three months of 2012 and...?

John Allison: This will actually – the way the rule is written right now. You actually do have to have that 90-day period of 30 percent Medicaid patient volume in the previous calendar year. Now, I will say, though, that as it has been proposed in the stage two rule, this could change.

What we've proposed is to allow that 90-day period just be in the – in the previous 12 months prior to attestation. But right now, it does have to be in the previous calendar year for determining your Medicaid patient volume. That 90-day period, it does have to be 90 days in the previous calendar year.

Melonie Roberts: OK. Thank you.

John Allison: Sure.

Operator: And your next question comes from the line of Sandy Privetera.

Sandy Privetera: Hi. Can you hear me?

Robert Anthony: Yes.

John Allison: Yes.

Sandy Privetera: OK. I wasn't sure. I know this is going to seem like a silly question.

But for the stage one, Meaningful Use, the 40 percent e-scribing figure and the 80 percent of all patients have to be in the EHR.

Robert Anthony: Yes.

Sandy Privetera: Does that refer to Medicare patients or all patients?

Robert Anthony: That's not a silly question at all. We've gotten that question before. And in fact, there is an FAQ on this on our Web site.

We do apply it to all patients, and we applied it to all patients because we got significant feedback when we were putting the program together and put the regulation out for comment that it would be a difficult thing for many

providers to try and separate out Medicare and Medicaid during the clinical process. So, it is 40 percent of all patients.

Sandy Privetera: OK, OK. Thank you.

Operator: And your next question comes from the line of Linda Kidd.

Linda Kidd: Hi, Linda Kidd. I'm with Aria Health Physician Services. And, now, I'm feeling kind of stupid because the other question that was answered may have answered mine.

From slide 20 and then some of the other slides that I've been going through, I wanted to make sure that all we're looking at is Medicare patients when we submit the aggregate numerator/denominator and exclusion data by attestation.

Robert Anthony: No. You'd actually for both Meaningful Use objectives and Clinical Quality Measures, it's going to be all patients.

Linda Kidd: All patients.

Robert Anthony: It won't be just Medicare.

Linda Kidd: And I heard that, yes.

Robert Anthony: Yes.

Linda Kidd: OK. So, it's not just Medicare. And, again, I want to be clear.

Payments for managed care Medicare patients are going to come from the managed care organization?

Robert Anthony: It's going to go through your managed care organization.

Linda Kidd: OK. OK. But we still attest obviously through Medicare or CMS?

Robert Anthony: No. MA – M – Medicare Advantage EPs are actually – their attestation is also going to happen through the MAO. So, if you're – if you have EPs who are

working with the Medicare Advantage organization, you should get in contact with that MAO and find out what they're doing right now as far as attestation and everything else.

Linda Kidd: OK. That's important. Thank you.

Maria Michaels: I just wanted to add one quick point regarding the Clinical Quality Measures.

Linda Kidd: Yes.

Maria Michaels: You need to attest to whatever it is that your EHR has calculated. So, your EHR would do all of that for you.

Linda Kidd: OK. So. So, we can't really submit the numerator/denominator and exclusion data until we started using the EHR?

Robert Anthony: Absolutely. Your – what's your stage of your – stages of progress on this are that, you know, you will register, you will go get a certified EHR. Maybe you got a certified EHR and then you register.

Those can go back and forth.

Linda Kidd: OK.

Robert Anthony: Then, you will do 90 days of Meaningful Use.

Linda Kidd: OK.

Robert Anthony: And then, you will actually come to our Web site and attest.

Linda Kidd: OK. Thank you very much, sir.

Robert Anthony: Certainly.

Linda Kidd: Yes.

Operator: Your next question comes from the line of Robert Davis.

Robert Davis: Good afternoon. My question is, we're an FQHC for the little – I'm the health director for the Little River Band of Ottawa Indians – Tribal Health Clinic. We employ two physicians to see our tribal citizens.

If they were to enroll in the EHR Incentive Program, they would be obligated to turn their – to turn the payment over to the clinic. My question is, how do you do that with the – with the tax ID number? When it comes down to entering it, do you put in the tribe's tax ID number, so that they don't get it...?

John Allison: All right.

Robert Davis: Get it added to their income.

John Allison: Right and it would – right. You would put in the tax ID number of who you want to be the recipient of the – of the incentive funds. So, correct, you would put in the tribe's, or THC clinic's tax ID number.

That's what you would do.

Robert Davis: OK. That's my question. Thank you very much.

John Allison: Sure. Thank you.

Operator: And your next question comes from the line of Nancy Thompson.

Nancy Thompson: Hi, this is Nancy Thompson from St. Joseph's Hospital and primary care clinic. My question – I'm just looking for clarification on the Clinical Quality Measures. There is a core measure, one of the 15, I think it's number 10, where you're saying yes that you do it and you attest that you do it.

And then, it sounded like there was then two options to then do your six quality measures. You're either doing that then and putting in the numerator and denominator data that you get out of your EHR, or you're doing that through like a registry like we're doing currently with PQRS or something like that. Is that – is that correct?

Maria Michaels: I'm not actually following which one – which one you're talking about in terms of needing to do something other than report what your EHR has calculated.

Robert Anthony: Are you talking about the option between putting your data in through attestation or putting in through the electronic reporting pilot program?

Nancy Thompson: Yes.

Maria Michaels: OK. So, if you choose the option for reporting via attestation, you would take the report that your EHR generates with the calculations for each of the Clinical Quality Measures and then attest to them in the same way that you attested with the Meaningful Use objectives where you would include your numerator, denominator, and exclusion. If you choose the electronic reporting pilot, you would then follow the instructions there, which would lead you to the portal in PQRS where you would submit your measures electronically and you would follow the instructions essentially as the PQRS EHR reporting option.

Nancy Thompson: Now, the part that confuses me is that we don't get the – we don't actually do the PQRS until like the beginning of the next year, the following year. So, like, right now, we just submitted PQRS 2011. So, we won't submit PQRS 2012 until, you know, March of 2013. But we will obviously want to attest for Meaningful Use in 2012.

Maria Michaels: You would be able to – well, you would be submitting for the EHR Incentive Program for 2012 in January and February of 2013.

Nancy Thompson: So, you're saying we can't attest – we have to wait to attest if we're going to use PQRS?

Robert Anthony: So, you haven't attested for Meaningful Use, right? You haven't done a 90-day period.

Nancy Thompson: No. We want to do our 90-day period this year and in 2012.

Maria Michaels: OK. I'm sorry, I missed that. So, then, if you are in your first year and using a 90-day reporting period, then you would have to attest.

Electronic reporting pilot is if in your second year or beyond because it requires a full year reporting.

Nancy Thompson: OK. So.

Maria Michaels: Sorry.

Nancy Thompson: OK. And 2011 does not count as...

Maria Michaels: If you...

Nancy Thompson: The PQRS from 2011.

Maria Michaels: If you did not participate in the EHR Incentive Program and successfully complete Meaningful Use, then no, it doesn't count. You would have to have done your 90-day reporting period in 2011. So, that should be the case for 2012.

So, if 2012 is your first year as Meaningful Use and you are completing your 90-day attestation some time during the course of 2012, then that becomes your first year. And then, the next time you can participate in electronic reporting would be in 2013.

Nancy Thompson: OK, great. Thank you.

Operator: And your next question comes from the line of Cathy Craig.

Cathy Craig: Yes. I just have a question – I'm not sure. We are just – we just – we are ready to purchase an EHR.

So, if I'm understanding correctly, I have to wait before I can go into Meaningful Use to get like a signed agreement to implement this program or like I don't understand how I...?

John Allison: You don't have to have a certified EHR in order to register.

Cathy Craig: OK.

John Allison: OK. But when you come back to attest, you need to have a certified EHR.

Cathy Craig: OK.

John Allison: You won't be able to get any further in the CMS registration and attestation system other than just registering if you don't have a certified EHR and if you don't input that EHR certification number that we were briefly discussing earlier.

Cathy Craig: OK. And I can do – we can do it for 90 days this year. And then, when will the first payment come, in 2013?

Robert Anthony: So, you.

Cathy Craig: Where you have...

Robert Anthony: If you did your 90 days immediately and, you know, you submitted at the earliest opportunity which would be in the beginning of April.

Cathy Craig: OK.

Robert Anthony: You would receive a – six to eight weeks would normally be your payment.

Cathy Craig: OK.

Robert Anthony: But you.

Cathy Craig: But.

Robert Anthony: Could submit later in the year. It sounds like you don't have the EHR yet.

Cathy Craig: No, we haven't one picked out.

Robert Anthony: So, you have to pick it.

Cathy Craig: But we haven't actually purchased it yet.

Robert Anthony: I got you. So, once you actually have that and you complete your 90 days, as soon as you submit that attestation, you usually get a payment within about six to eight weeks.

Cathy Craig: OK. Thank you.

Robert Anthony: Sure.

## **Additional Information**

Diane Maupai: This is Diane Maupai. I'm afraid we're out of time for questions today. On the last slide in the deck, you will find information and a URL to allow you to evaluate your experience with today's call.

All evaluations are anonymous and strictly confidential. And on Monday, you will get a reminder e-mail from CMS National Provider Calls regarding the opportunity to evaluate the call. So, if you've already completed that evaluation, just ignore that e-mail.

If you still have questions after today's call, be sure to – you can call the EHR information center, and you will find the phone number on slide 48. And we encourage you to look at our EHR incentives page on cms.gov, and the link there is on page 47. So, I'd like to thank everyone for participating in today's call.

The audio recording and transcript will be posted to the National Provider Call site and the EHR pages in about two weeks. So, stay tuned for more information about the next upcoming call for eligible professionals, which will cover registration and attestation in more detail. Again, my name is Diane Maupai.

It's been a pleasure serving as your moderator. I'd like to thank Rob Anthony, and John Allison, and Maria Michaels for their participation today. So, have a great evening, everyone.

Operator: Thank you for your participation on today's call. You may now disconnect.

END