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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Stage 1 and Stage 2 of Meaningful Use for the EHR Incentive Programs
MLN Connects National Provider Call
Moderator: Diane Maupai
July 24, 2013
1:30 p.m. ET

Contents

Operator: At this time, I would like to welcome everyone to today's National Provider 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.

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

Announcements and Introduction

Diane Maupai: Thank you, Victoria. This is Diane Maupai. I'm from the Provider Communications Group here at CMS in Baltimore, and I'm happy to be your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on Stage 1 and Stage 2 of Meaningful Use. MLN Connects calls are part of the Medicare Learning Network.

During this call, we have a number of subject-matter experts who'll be providing information on Stage 2, and then a question-and-answer session will follow the presentations.

Before we get started, I have a couple of announcements.

You should have received a link to the slide presentation for today's call in previous registration emails. If you've not already done so, please download the presentation from the following URL: www.cms.gov/npc. Again, that's www.cms.gov/npc. At the left side of the webpage, select National Provider Calls and Events, then select the date of today's call from the list.

Second, this call is being recorded and transcribed. An audio recording and written transcript will be posted to the MLN Connects Call website. An announcement will be placed in the MLN Connects Provider eNews when available.

I also want to remind everybody that the next call in this series will be held on Thursday, August 15th, and the topic will be Payment Adjustments and Hardship Exceptions.

At this time, I'd like to introduce our speakers. From the Office of E-Health Standards and Services HIT Initiative Group, we have Travis Broome, who's the team lead for Policy and Oversight, and Vidya Sellappan, Health Insurance Specialist on the HIT Policy and Oversight Team. From the Center for Clinical Standards and Quality, we have Maria Michaels. She is the lead for HITECH CQM Policy and Operations. From the Center for Medicaid and CHIP Services, we have David Koppel, who is the Medicaid HITECH co-lead.

And in terms of what we're going to be covering today, Vidya is going to start us off with an overview of the rule and eligibility for the program and also talk about Meaningful Use. Maria is going to follow and talk about clinical quality measures. Travis will come

on and talk about payment adjustments and hardship exceptions, and David Koppel will finish up with Medicaid changes and Stage 2 resources.

With that, I'd like to turn it over to Vidya.

Presentation

Vidya Sellappan: Thank you, Diane, and thank you to all of you that are on the phone. We're glad to have an opportunity to talk to you about the EHR Incentive Program, as well as share with you some changes to Stage 1 Meaningful Use, as well as introduce or provide details about Stage 2 of Meaningful Use, which gets under way in 2014.

So with that, I'll get started on slide 5. Starting in 2014, providers participating in the EHR Incentive Program who have met Stage 1 for at least 2 years will then need to start meeting Meaningful Use using the Stage 2 criteria. Stage 2 includes new objectives as well as enhanced objectives to – that focus on improved patient care through clinical decision support, care coordination, and patient engagement.

And a little bit later in the presentation we'll talk about our path to moving through the stages of Meaningful Use. The most important thing to know about Stage 2 is that its objectives seek to foster the use of EHRs to help improve care and outcomes as well as reduce costs and save time.

Stage 2 Eligibility

Now I'm going to speak to you about Stage 2 eligibility. On slide 7: The EHR Incentive Program was established through the HITECH Act in 2009. Since then, there has been no major change – no changes to the HITECH Act, and eligibility requirements have remained mostly unchanged. The only eligibility changes are those within our regulatory purview under the Medicaid EHR Incentive Program.

On slide 8, one small eligibility clarification that I do want to bring to your attention is how we define hospital-based eligible professionals, or EPs. As many of you know, in Stage 1 we indicate that EPs must be considered non-hospital-based in order to participate in the incentive programs. In Stage 2 we provide a little bit more clarification and indicate that in lieu of using the hospital's certified EHR technology, if an EP can demonstrate that they fund the acquisition, implementation, and maintenance of a certified EHR—including supporting the hardware and interfaces needed for Meaningful Use—without any reimbursement from an eligible hospital or critical access hospital, or CAH, that they may be determined to be non-hospital-based and could potentially receive an incentive payment. Of course, this determination will need to be made through an application process.

Stage 2 Meaningful Use

Next, I want to go – the next several slides, I want to go over Meaningful Use. And I'm going to start on slide 10. On slide 10 we have a visual that takes us through the various stages of Meaningful Use and where we're looking to go. So when providers join the incentive program, they start with Stage 1, and Stage 1 focuses primarily on capturing

and sharing data in a structured way. And when I say "structured data," I mean a format that can be recognizable by the people that – the users of the data, as well as that the data can interact with other data and systems.

As we move towards Stage 2, the focus becomes less on gathering the data and more on encouraging the use of the data that is being gathered, in an effort to advance clinical processes. The objectives of Stage 2, as you'll see in slides – in the slides a little bit later, seek to support clinical decisionmaking, foster patient engagement, and encourage seamless care coordination.

And as we move towards Stage 3, we'd like to build on some of the successes that we've had – that we had in Stage 1 and Stage 2. Essentially, in Stage 3, we're looking to make sure that the data that is collected is leveraged in such a way that produces improved outcomes.

So, essentially, this diagram – I just want to reiterate – we want to get to a point where we start out collecting data, but by the end of this Meaningful Use process, or in the future, we want to make sure that EHR technology is part of the process and – make – and part of the foundation of how patient care is delivered.

On page 11, I want to – go to page 11 – slide 11. This is a table that goes through the Meaningful Use path that Medicare EPs follow depending on when they start participating in the EHR Incentive Program. As you'll see, in 2011 and forward, providers participate in Stage 1 for approximately 2 years before they move on to Stage 2, and they participate in meeting Meaningful Use using the Stage 2 criteria for 2 years before going on to Stage 3.

As you'll notice, in 2011 – those who started in 2011, who we call early adopters—they will participate in Stage 1 Meaningful Use for 3 years rather than 2 years. And that's because Stage 2 doesn't officially get under way until 2014. I neglected to mention that this table also indicates the potential incentive payment that could be earned if a provider – an EP successfully attests to Meaningful Use.

On a side note, Maria Michaels is going to talk about clinical quality measures, or CQMs. But I wanted to point out that, starting in 2014, the CQMs that are required to be reported are going to be the same for everyone, no matter what stage of Meaningful Use you're participating in.

Next slide, slide 12: This is a similar table to the one we just saw, but this one pertains to Medicare hospitals. As you'll see, hospitals participate in Meaningful Use at the Stage 1 criteria level for 2 program years before moving on to Stage 2, which they will meet for 2 more years before they move on to Stage 3. Again, early adopters who started in the incentive program in 2011 will participate in Stage 1 for 3 years and then in 2014, move on to Stage 2.

On slide 13, I want to start there – the next several slides are going over Meaningful Use and, particularly, Meaningful Use objectives.

There have been some changes in the types of objectives that are going to be required in Stage 1 versus in Stage 2. As you'll see, in Stage 1, eligible professionals are required to meet 15 core objective measures—"core" meaning that they are mandatory—and 5 out of 10 possible menu objectives, for a total of 20 objectives. As these eligible professionals move to Stage 2, the number of core objectives increases to 17, while the number of *menu* objectives decreases to 3 out of a possible 6.

For eligible hospitals and CAHs, the number of core objectives required for Stage 1 is 14, and the number of menu objectives is 5 out of a possible 10, for a total of 19 total objectives. As these hospitals move toward Stage 2, the number of core objectives increases to 16, while the number of menu objectives decreases to 3 menu objectives out of 6.

On the next page I do want to point out one change in how menu and core objectives are calculated. The main change is that if a – if an exclusion is claimed on a menu objective, that menu objective cannot be counted toward the number of menu objectives required to meet Meaningful Use.

So, for example, currently, if an EP selects 1 out of the 10 menu objectives and chooses to claim an exclusion for that menu objective, currently that provider can count that particular menu objective towards the 5 that they need to report for Meaningful Use. Starting in 2014, that menu objective, if an exclusion is claimed for that, cannot count toward the five that they need to meet for Stage 1 Meaningful Use. So that's one change.

But there are certain things that have not changed. The threshold of outpatient encounters – at least 50 percent of EP outpatient encounters must occur at locations equipped with certified EHR. One clarification I want to make is that measure compliance is essentially equivalent to objective compliance. The objective is what we seek to accomplish. The measure is how we calculate or determine that that objective has been met. So if you meet the measure associated with an objective, that is considered meeting the objective.

And as far as denominators in measures are concerned, the denominators should be based on all outpatient locations certified with certified – equipped with certified – with certified EHR technology. You'll want to look at the specific measure specifications to see how the denominator is being calculated, but this denominator should be based on all outpatient locations that have a certified EHR.

I'm going to go on to slide 15 and talk about standards and certification. Starting in 2014, all EHR Incentive Programs participants will have to adopt certified EHR technology that meets ONC's Standards and Certification Criteria 2014 Final Rule. And as a way to allow providers time to adjust and adopt to these new standards, as well as prepare for the upcoming Stage 2, in 2014 all participants will have a 3-month reporting period in 2014.

So let me reiterate. Whether 2014 is the first year that you're participating in the EHR Incentive Program, or if you have participated in prior years, in 2014 the reporting period will be a 3-month period. This is regardless of the fact that if you participated in previous years and you had – whether you had a 90-day reporting period for your first year or one – a 12-month reporting period for subsequent years, in 2014 you will have a 3-month reporting period.

On the next slide, slide 16: One feature that we are introducing in 2014 is batch reporting. Provider groups will be allowed to submit attestation information for all of their individual EPs in one file that they can upload to the attestation system. This is will help alleviate the burden of having to enter attestation information for each EP individually.

On slide 17, we're going – the next several slides are going to list out the new – the objectives for Stage 2. I don't want to go through and read each one one-by-one, but I do want to point out – slide 17 starts with the core objectives for Stage 2, and I want to point out that many of these objectives listed are the same or similar to the core objectives that were part of Stage 1. Some of the only differences are higher threshold – thresholds, or some of the menu measures from Stage 1 moving to core measures in Stage 2.

And there are a few new objectives that we'll talk about in future slides. But a few that I want to point out—I mentioned that some of these are the same objectives from Stage 1 with higher thresholds. If you'll notice, the core objectives for demographics, vital signs, and smoking status, you'll notice that it says record for more than 80 percent of patients. In Stage 1, this was 50 percent. So now we're asking for a higher level of reporting on these particular items.

In addition, if you look at the first core objective listed, CPOE: in Stage 1, the measure required that 30 percent of medications use CPOE. In Stage 2, you'll notice that not only is that percentage for medication increased to 60 percent, this particular objective also focuses on laboratory and radiology.

Another thing I want to point out is that, in the past, reporting CQMs was considered a core measure. Though you're still required to report CQMs, reporting CQMs is no longer considered an objective in Stage 2.

I'm going to go to the next page. This is a continuation of the core objectives for Stage 2. You'll notice patient access: The description of what this includes slightly varies from Stage 1. You'll notice there are a couple of new measures – new objectives, to include No. 13, secure messages. I'll speak a little bit to this in a future slide, but I wanted to point that out.

Slide 19 lists the menu objectives that can be selected for Stage 2. There are six of them here. I will point out again that in – starting in 2014, claiming an – claiming an exclusion for any of these menu objectives does not count towards the menu objectives required to meet Meaningful Use.

On slide 20, 21, and 22, these are the core objectives and the menu objectives for eligible hospitals. Again, I'll reiterate, some of these are the same objectives that were required in Stage 1, with higher thresholds. Some of them have slightly different requirements. And there are a couple of new objectives as well.

So I'm going to move on. On our website, we have plenty of information and – about objectives, with details. So feel free to visit our website for more information.

I'm going to go on to slide 23. And earlier on, I had mentioned that Stage 2 focuses on several different areas, and one of those main important areas is patient engagement. We have two measures that focus exclusively on patient engagement. The new measure, secure messages, focuses on requiring that more than 5 percent of patients send secure messages to their EP. Another objective is the patient access objective that focuses on view online, download, and transmit. And this requires that more than 5 percent of patients access their health information online.

And, as you can see, these particular measures have more to do with patient action than just a provider submitting information or doing something. So that's very important. It's a big difference from what we required in Stage 1. Of course, CMS is going to introduce exclusions based on broadband availability in provider counties.

Slide 24: Another area that Stage 2 focuses on is electronic exchange. And the summary of care measure which, in Stage 1, required that a summary of care record was created and submitted for 50 percent or more of transitions-of-care referrals, is still applicable in Stage 2. In addition, Stage 2 requires that, of the summary of care records that are created, more than 10 percent of them are electronically transmitted. In addition, at least one summary of care document must be sent electronically to a recipient with a different EHR vendor or to a CMS test EHR.

And I know that there are several questions that many of you have about what should be included in the summary of care record and what shouldn't. I will tell you that our website has plenty of details and includes details about the base requirements specified for a summary of care record. All other information is based on provider discretion.

I'm going to move on to stage 25, and I'm going to start talking about some changes to actual objectives and measures.

The first one is computerized physician order entry. The main difference here is that there is an additional option on how to calculate the denominator. Currently, the Stage 1 measure requires that the denominator be counted as "the unique patient with at least one medication in their medication list." Starting in 2013, the denominator can, alternatively, be calculated as the number of orders during the EHR reporting period.

Next slide, slide 26: This is a change to vital signs, and this is essentially just a modification based on existing clinical guidelines and best practices. Currently, in Stage 1, the age limits for reporting blood pressure and height and weight is starting at age 2.

We're changing that starting in 2013 to age 3. Again, both of these – it's optional in 2013; starting in 2014, the new Stage 1 measure is what we'll be using.

Again, in the current Stage 1 measure, as far as exclusions are concerned, the exclusion requires that all three elements not – be not relevant to the scope of practice. The new Stage 1 measure will allow you to claim an exclusion for one of those items. So it's either blood pressure or weight or height. And, again, these changes are optional in 2013, but they go into effect on a mandatory basis in 2014.

Slide 27, testing of HIE: This is one measure that's been removed. In the current Stage 1 criteria, we require one test of electronic transmission of key clinical information. As you'll see, effective in 2013, this has been removed.

I'm going to go on to slide 28. And this particular change has to do with the measure now in Stage 2 entitled "patient access." In Stage 1 we did want the ability for patients to be provided with an e-copy of their health information upon request and provide them with electronic access to health information. And in Stage 1, the new objective, we've actually clarified it a little bit more, to say that we want to enable patients to have the ability to view online, download, and transmit their health information. And this particular language goes into effect in 2014 to coincide with the certification and standards criteria.

I'm going to move on to slide 29. And this objective has to do with the public health – the three public health objectives. Nothing has changed. We still – in Stage 1, the current objective, we still require the submission of data as it pertains to immunizations, reportable labs, and syndromic surveillance. Nothing has changed except that we have added the language "except where prohibited" to all three objectives, so that we can take into consideration providers who are in areas where they are prohibited by local laws and regulations.

And that's all I have, so I'm going to turn it over to Diane.

Keypad Polling

Diane Maupai: OK. Thank you, Vidya.

At this time, we're going to pause for a few moments to complete keypad polling so that CMS has an accurate count of the number of participants on the line with us today. Please note, there will be a few moments of silence while we tabulate the results.

Victoria, we're ready to start polling.

Operator: CMS appreciates that you minimize the Government's teleconference expense by listening to these calls together using only one phone line. 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 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room,

enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding number. If there are nine or more of you in the room, enter 9.

Please hold while we complete the polling.

Thank you. I would now like to turn the call back over to Ms. Diane Maupai.

Diane Maupai: Thank you very much, and I'm going to turn it over to Maria Michaels, who's going to talk to us about clinical quality measures.

Presentation Continued

Clinical Quality Measures

Maria Michaels: Thank you, Diane.

So I'm going to begin, again, on slide 31. In this – in this slide, we're talking to you a little bit about the CQM reporting in 2013. That's the year we're currently in, and you're, hopefully collecting some data if you're an eligible professional or an eligible hospital or CAH.

And for EPs, the CQM requirement remains the same. It includes the 44 CQMs that were finalized in the Stage 1 rule. The reporting schema is still three core or alternate core CQMs. If you're reporting any zeroes in the core CQMs, you'd have to select an alternate core to sort of replace the one that you didn't have any patients for, and then three additional CQMs, for a total of six, or up to nine CQMs if you had any zeroes in the core CQMs.

For eligible hospitals and CAHs, this includes 15 CQMs—again, also finalized in the Stage 1 rule—and the requirement is to report all 15 of those CQMs.

In 2012, and then continued in 2013, there were two reporting methods available for reporting the Stage 1 CQMs. The first was attestation – or *is* attestation. And so both EPs and eligible hospitals and CAHs could still go through the registration and attestation systems and report their CQM data for their required CQMs. Or, you had the option of participating in the eReporting Pilot. For the EPs, this was the Physician Quality Reporting System EHR Incentive Program Pilot, and for hospitals, it was the eReporting Pilot for eligible hospitals and CAHs.

For Medicaid providers, you were supposed to submit your CQMs according to your State-based submission requirements, and that remains the requirement in 2013. So check with your State to be sure you're reporting your CQMs appropriately.

On slide 32: A little bit about the CQM specifications in 2013. One of the things we chose not to do was update the specifications so that the focus could be a little bit more on preparation for reporting in 2014. Since there were going to be a lot of changes, we

wanted to be sure that we got sort of the mechanisms in place. And so we have kept those the same for 2013.

We also wanted to afford you some flexibility in implementing your certified EHR technology. If you wanted to do so early for those technologies that are certified to the 2014 edition certification criteria—again, that's ONC's certification criteria—you could do so in 2013 and still report your clinical quality measures through attestation. And I did want to point out that for EPs, this would reduce the number of CQMs that are available, because the CQMs have to be available in both the Stage 1 and Stage 2 final rules.

In slide 32, you can see the list by NQF number of the specific CQMs that were not continued on in the Stage 2 rule. I'm not going to read them all out—there's 12 of them. But I did want to point out that NQF 0013 is currently, in the Stage 1 final rule, a core CQM. So you would just use that same rule, providing an alternate core CQM, because you wouldn't be able to report any data for NQF 0013.

I also wanted to mention that for eligible hospitals and CAHs, all 15 of the CQMs from the Stage 1 final rule were continued into Stage 2. So all 15 of them would still be available if you chose to adopt your 2014 edition technology a little bit early.

Moving on to slide 33: So Vidya mentioned this earlier. You probably already noticed this, but I think it bears repeating that the CQMs are no longer a core objective of the EHR Incentive Programs beginning in 2014, but they are still required to be reported. So—still a required element of reporting to meet Meaningful Use.

Slide 34: A little bit about how we selected the clinical quality measures and how we want you to report them beginning in 2014. So, you will notice that in your reporting requirements—and I'll go over those in a little bit more detail in a few more slides—but there's a requirement to report CQMs from at least three of the six National Quality Strategy domains. These include patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical processes and effectiveness.

And you may have noticed that some of the objectives that Vidya went over also kind of include some of these same themes. These are the themes that, on a national scale, we have all sort of agreed to and want to promote and figure out better ways to actually execute in our health care delivery system.

Slide 35: So we have hopefully drilled this point across to everyone, that it is definitely CMS's commitment and intent to continue to align across quality reporting programs. One of our big goals is to reduce your reporting burden. We know that this is not necessarily your highest priority. Of course, patient care is.

And so, in kind of helping out, we hope to continue our alignment efforts and wanted to point out a couple of the ones that we've already sort of begun efforts on. So we've got

some alignment efforts with hospital IQR, with PQRS, with CHIPRA, and Medicare Shared Savings Program and Pioneer ACOs.

Slide 36: A little bit more on this alignment thing. We've got some reporting mechanisms that kind of give you the more practical side to this and what exactly it would mean for you when you're reporting your clinical quality measure data.

So the table on slide 36 gives you a little bit of a summary, depending on the type of provider you are. So if you're an eligible professional, your requirements include – or your options include submitting once and getting credit for CQM requirements for Physician Quality Reporting System, PQRS. And that would be using the EHR reporting option. If you're in a group practice, you could use the PQRS GPRO option. Or, if you're part of an ACO, either under the Medicare Shared Savings Program or a Pioneer ACO, you can report using the requirements for either of those programs and get your credit for your CQMs in Meaningful Use. I do want to point out that you still have to submit your Meaningful Use functional measures through the registration and attestation system to complete your Meaningful Use requirements.

Likewise, if you're an eligible hospital or CAH, we have implemented that eReporting Pilot that will end up being, essentially, the reporting – the electronic reporting option beginning in 2014. And you may have noticed that we have proposed in both the Medicare physician fee schedule as well as the inpatient prospective payment schedule a few additional alignment options, including, on the hospital side, with the Hospital Inpatient Quality Reporting Program.

Next slide, slide 37: A little bit about electronic submission of CQMs beginning in 2014. So, as of today, beginning 2014, Medicare-eligible providers in their second year and beyond of demonstrating Meaningful Use must electronically report their CQM data to CMS. I mentioned "as of today" because you may have noticed in the inpatient prospective payment schedule that we also mentioned that for eligible hospitals and CAHs who want to submit aggregate data, you can do so by attestation in 2014 because we won't have the technical ability to accept QRDA III, or Quality Reporting Document Architecture Category III, files. Those are the aggregate-level files. So, if we finalize this in the IPPS final rule, that will – that will be a slight exception to this particular rule.

I also wanted to point out that if you are a Medicaid provider participating in the Medicaid EHR Incentive Program, you'd be reporting your CQM data to your State, which may or may not include electronic reporting. So, again, you may want to check with your State to see what the requirements are.

Slide 38: A little bit about the CQMs beginning in 2014. I wanted to point out that we do have the complete list of CQMs required for reporting beginning in 2014 on the EHR Incentive Program's website. And you'll see that at the bottom in the first bullet on slide 38. This also includes the associated National Quality Strategy domains and the specifications for each of those clinical quality measures.

I did want to point out that if you are an eligible professional, we did include a recommended core set of CQMs that focus on high-priority health conditions and best practices for care delivery. We have nine recommended core CQMs for adult populations and nine, also, for pediatric populations.

I did want to kind of focus on the word "recommended" because, although this is called a core set of sorts, it is not required that you report these particular CQMs. But we wanted to provide you kind of a way to have a starting place, that this list may be the place that you start looking when selecting which CQMs you'll report to CMS beginning in 2014.

On slide 39: A little bit more information for how you – we chose the CQMs that are on those recommended core lists for EPs. We selected them based on several factors. And those factors include conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries; conditions that represent national public and population health priorities; conditions that are common to health disparities; then, continued on slide 40: conditions that disproportionately drive health care costs and could improve with better quality measurement; measures that would enable CMS, the States, and the provider community to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement; and, also, measures that include patient or caregiver engagement.

Moving on to slide 41, on CQM reporting. You heard Vidya mention this earlier, but unlike the Meaningful Use objectives and measures, the clinical quality measure requirements are not associated with the specific stage of Meaningful Use that a provider is in. What you need to pay attention to is what year it is. So, the CQM requirements depend on the year that you are collecting and then reporting the data to CMS. So that's why we've been referring to the requirements for CQMs, for example, beginning in 2014.

And I also wanted to remind you that your CQM requirement is that you are to report what your certified EHR technology give you as an output. We want to see what your certified EHR technology captures and calculates.

Slide 42: Some changes to CQM reporting. So, again, I just mentioned that it depends on what year it is, what the requirement is. So, prior to 2014, if you're an EP, you would be reporting 6 out of the 44 CQMs that were finalized in the Stage 1 rule. And you would be reporting them according to the schema of three core or alternate core CQMs and three additional or menu CQMs.

Beginning in 2014, again, for EPs, the requirement will be reporting 9 out of 64 CQMs that were finalized in the Stage 2 rule, and those 9 need to cover at least 3 of the 6 National Quality Strategy domains. And, again, you can start at the recommended core CQMs which, if you chose all of the core CQMs, for example, in the adult population, you would already be covering your 3-of-the-6-domains requirement.

For eligible hospitals and CAHs, prior to 2014, your reporting requirement was to report all 15 out of the 15 CQMs finalized in the Stage 1 rule. And then, beginning in 2014, the

requirement changes to reporting 16 out of 29 CQMs. And, just like the EPs, the requirement is also to select 3 CQMs that cover or – sorry – select at least 3 of the 6 National Quality Strategy domains within that list of 16 CQMs.

Next slide, slide 43: A little bit more about EP CQM reporting beginning in 2014. This is a pretty big table on this slide, so I'm not going to go through it cell by cell, but I did want to mention that it includes the reporting requirements and schemas—submission type, payer level, all of that—for EPs in their first year of demonstrating Meaningful Use, beyond the first year of demonstrating Meaningful Use, as well as EPs and group practices. So, if you kind of use this slide, you have your choice of how you report in 2014, and you can figure out which one fits your particular situation the best.

I did want to point out that the reason why attestation is required for EPs in their first year of demonstrating Meaningful Use is because that's the only way you can meet the deadline to avoid the payment adjustment, and that deadline is October 1st. If you, for example, in 2014, don't report your Meaningful Use functional measures and clinical quality measures by October 1st, 2014, you will be experiencing a negative payment adjustment in 2015. So we do want to make sure that you are able to report your CQM data.

Next slide, slide 44: For hospitals in CQM reporting beginning in 2014, sort of a similar table—a little bit less crowded, I guess. But if you are a hospital in your first year of demonstrating Meaningful Use in 2014, you have a similar deadline to demonstrate Meaningful Use in order to avoid the payment adjustment, and that deadline is July 1st, 2014.

The same sort of result would happen if you don't meet your Meaningful Use functional objective and clinical quality measure reporting requirements by July 1st: You would experience a negative payment adjustment in 2015.

I did want to point out that we have a proposal in the fiscal year 2014 inpatient prospective payment schedule NPRM that would allow hospitals in any year of demonstrating Meaningful Use to attest aggregate data or electronically submit patient-level data. So you would be able to have your choice of that. But even if you electronically report your CQMs, if you're a hospital in your first year of demonstrating Meaningful Use, you have to pay really close attention to that July 1st deadline.

Moving on to slide 45: For hospitals, we have allowed a CQM case number threshold exemption, and we've applied this beginning in fiscal year 2013 for all stages of Meaningful Use. If you want to use this exemption for any of the clinical quality measures, you have to submit the admin data for each reporting period to justify the exemption—that's basically the aggregate population data for each CQM—to let us know how many cases that you actually had that sort of supports your attempt to get this exemption.

The threshold for exemption from reporting a CQM during the relevant EHR reporting period is a little bit different, depending on how long your reporting is. So, for example, if you're in your first year of demonstrating Meaningful Use—or, really, any stage of Meaningful Use in 2014—you would have a 90-day EHR reporting period or a one-quarter reporting period, which for all intents and purposes is about the same. You would need to demonstrate that you have five or fewer discharges within that reporting period in order to qualify for the exemption for that particular clinical quality measure.

If you're in your second year or beyond of demonstrating Meaningful Use and you have a full-year EHR reporting period, you would have to have 20 or fewer discharges in order to be able to invoke this case threshold exemption. The way that you determine whether or not the discharges fit the requirements is in the definition of the denominator population. So it is defined on a CQM-by-CQM basis and is also applied on a CQM-by-CQM basis.

Slide 46: A little bit more about how you invoke this case threshold exemption. It's a little bit different in 2013 than it is beginning in 2014, so I just wanted to make sure that we clarified the differences.

So, I mentioned earlier that for hospitals reporting in 2013, all 15 of the CQMs from the Stage 1 final rule are required. So in order to meet that requirement, you need to submit either CQM data or be exempted from being able to submit those clinical quality measures.

Diane Maupai: This is Diane. I understand that we are having some problems with the audio. We're looking into it and we'll fix it as quickly as we can. But we'll go on for the – because we don't know how widespread the problem is.

Maria Michaels: OK. Thank you, Diane.

So we're still back on invoking the case threshold exemption in fiscal year 2013. If you are attempting to do this, and you do actually quality for that exemption for any CQMs, you would essentially reduce the number of CQMs required by the number of CQMs for which the hospital doesn't meet the case threshold of discharges.

In – beginning in 2014, the requirement is to report 16 CQMs covering at least 3 domains from a list of 29 CQMs required. You basically use the same process as in fiscal year 2013, but in order to be exempted from reporting fewer than 16 CQMs, you would need to qualify for the case threshold exemption for more than 13 of the 29 CQMs. That means at least 14 of the 29 CQMs.

So if the CQMs for which the hospital can meet the case threshold of discharges does not cover at least three domains, the hospital would be exempt from the requirement to cover the remaining domains.

Moving on to slide 47, and this is about CQM timing: The summary of this is basically there's really no changes to the time periods from Stage 1 to Stage 2, but we did want to kind of summarize it again so you could keep it straight and figure out, based on your specific situation, what your reporting period and submission period would be.

I, again, wanted to reiterate the deadlines for avoiding the payment adjustments. For EPs, you would have to submit your CQMs and your Meaningful Use functional measures no later than October 1st of each year in order to avoid the payment adjustment the following year. And if you're an eligible hospital or – sorry, just eligible hospital, you would have to, again, submit your CQMs and Meaningful Use functional measures no later than July 1st of each year.

Next slide, slide 48: In 2014, we've mentioned a few times now that you could use a quarter – a one-quarter reporting period. The same is true for the clinical quality measure reporting. And so, we sort of included all that in a slide here where you could kind of see what it means for you if you're an EP or an eligible hospital or CAH. The quarters are fixed to either the calendar year if you're an EP, or the fiscal year if you are an eligible hospital or CAH.

I did also want to mention that if you are participating in the Medicaid EHR Incentive Program, you'll want to check with your State to see if they have the same requirement or have decided on a slightly different requirement. Again, in the footnote, you'll notice I have yet another reminder about that deadline for avoiding the payment adjustment. We really don't want you guys to have to get a payment adjustment.

Moving on to slide 49: I wanted to kind of conclude my section by showing you a couple of opportunities that we've provided in addition to public comment to our rules. We had a couple of requests for comment and requests for information. This includes the Health Information Technology Policy Committee request for comment on Stage 3 of Meaningful Use. All of these comment periods are closed, by the way. So, we can't accept any additional comments, but did want to let you know that we did take the comments that we heard from all of you into account when proposing the more recent physician fee schedule and inpatient prospective schedule rule. We also had a CMS request for information on hospital eReporting as well as EP eReporting.

And, with that, I'm going to turn it over to Travis.

Payment Adjustments and Hardship Exceptions

Travis Broome: Thanks, Maria.

Now we're going to talk about the hardship exemptions and the payment adjustments, which I'm sure is everyone's favorite topic. As Diane mentioned at the beginning of the call, this topic will be the subject of its own provider call in the near future. So I'm just going to kind of focus on the bare minimum here on this call, and then we'll go into much more detail next time.

On slide 50, there's really – when you think about payment adjustments, there's three big questions that you need to know: How much are they? When do they apply? And how do I avoid them? And so we're going to go over all three of those in relatively short order.

Clarification: The slide in the previous paragraph should be "slide 50"

The first slide, incidentally enough, on 51, is how we'd like you to avoid them. So this is our preferred method for avoidance of the payment adjustment, and that is simply to become a meaningful EHR user. Obviously, if you become a meaningful EHR user, either through Medicare or Medicaid program, you will not be subject to the payment adjustment. That's the whole point. The other way to avoid them is hardship exemptions, which we'll talk about in – at the end.

So this slide here, 52, talks about how much they are and when they hit effect. First of all, you have to be an eligible professional. If you are not eligible for the incentives—not whether you went for the incentives or not, but if you're not an eligible professional under Medicare, which is basically called doctors of something—so doctor of medicine, doctor of osteopathy, doctor of chiropracty, doctor of general surgery or dental medicine—you are not subject to the payment adjustments. If you are eligible, then you are. And this, basically, can lay you out the timeline for when the adjustments hit and the various amounts.

So when do we need to demonstrate Meaningful Use? Every year. It's an annual determination. It's probably the most important thing to remember. You must continue to demonstrate Meaningful Use every year. It's an annual determination. One year has no effect on other years.

So for most folks, it's going to be a rolling 2-year situation. So if you're started in 2011 or 2012, you need to demonstrate Meaningful Use in 2013 and then in 2015. We have to know whether to apply the payment adjustment at the beginning of the year or not because if we find out later that we were wrong at the beginning of the year, we have to reprocess all of those claims.

And if we go back up to slide 52, as you can see, with 1-percent, 2-percent, 3-percent payment adjustments, the cost of reprocessing those claims could easily and very likely would be more than the payment adjustment itself.

Same thing if your first year is 2013, same thing: Two years in advance except, you know, it's your first year, so you get that 90-day EHR reporting period.

If you've never demonstrated Meaningful Use before, when is that last date – that drop-dead date, if you will, to avoid the payment adjustments? And for EPs, that day is October 1st, 2014. You must end your EHR reporting period and attest to Meaningful Use by October 1st, 2014, which means you would need to start your EHR reporting period no later than July 1st, 2014. Do not do this. This is – this is the last day. The last thing anybody wants is, because of an administrative problem on October 1st or because your power went out or whatever, you were not able to become a meaningful EHR user.

The way to avoid that is not to plead for leniency from us, but just to move it forward, even if you can only move it forward a few weeks – 2 weeks or so. Obviously, 2 months would be much better. It gives you plenty of time to get everything straightened out. But certainly you should be shooting for at least a few weeks ahead of time so that we don't have any of these situations where something crazy happens on October 1st and there's nothing we can do about it. I don't want that to happen to you any more than you want it to happen to you.

I already mentioned Medicare or Medicaid. I'm obviously not going to read all of these slides to you. They are a great reference. They're more reference slides than presentation slides. So certainly keep this packet and refer back to them.

Hospitals – so, hospitals, this is how much and when for them. Pretty similar chart. Very different effect – affects the market – well, it used to be known as the market basket increase. Now it's just known as the update, the IPPS, and you would get 75 percent of the update in 2015, 50 percent in 2016, 75 percent off the update in 2017.

Hospitals —and this is our subsection D, our IPPS hospitals, and our Maryland hospitals—they still have that prospective period. It's the same thing as EPs on – as you can see on slide 58, just they operate on the fiscal year, not the calendar year.

Subsection D hospital—last chance, again, just move it forward 3 months with the fiscal year. Don't do this. The last thing we want is something to go wrong on July 1st and having a hospital be subject to a payment adjustment over something that could have been prevented if they had attested, you know, say, 2 weeks earlier or 2 months earlier.

Critical access hospitals are our last group. Slide 60 goes through the numbers for them. For those of you who aren't aware, a critical access hospital receives 101 percent of their reasonable costs reimbursement. Over time, they would lose the 1 percent and it would go down to a straight 100.

Slide 61 is the timing for them. Notice that it is different. Critical access hospitals do cost reporting, so they're given initial payments. And then at the end of the year, they're submitting, basically, actual costs, and those payments are reconciled. Those reconciliations result in variations of more than 1 percent in nearly every case.

So, because the – that would just – could be folded into that reconciliation process that exists for CAHs, CAHs can actually demonstrate Meaningful Use in the year of the payment adjustment, a unique thing that we're able to do for CAHs that we couldn't do with our fee schedules and our prospective payment schedules on the other side. So that's available for CAHs.

Finally, I mentioned we'll talk about last, hardship exemptions. Again, two ways to avoid a payment adjustment if you're a – if you're an eligible professional or eligible hospital: Demonstrate Meaningful Use on time, or apply for a – successfully apply for a hardship exemption. There's actually only three on this list that you need to apply for. It's 1, 3, and

– well, 1, 3, 4, and 5. And I'll go over – there's an aspect of 4 that you don't have to apply for.

Newly EPs, we're able to identify you administratively. So, infrastructure—you know, you don't have Internet access is the most common one, but other infrastructure concerns that might be a barrier: unforeseen circumstances—my EHRs didn't get re-certified, they went out of business, I went bankrupt, there was a natural disaster—this type of unforeseen, out-of-your-control circumstances.

EPs with nontraditional patient interactions—so, lack of face-to-face or telemedicine interaction, lack of followup need for patients—it's – both criteria are needed. And EPs who practice in multiple outpatient locations where they don't control the certified EHR technology availability. So, this commonly happens in ambulatory surgery centers for our surgeons. It might happen to a nephrologist with ESRD facilities. It might happen for a geriatrician with – who works most of their time in nursing homes.

So if you're in a situation where less than 50 percent of your encounters – or more than 50 percent, excuse me – more than 50 percent of your encounters occur at locations where you can't control whether they have certified EHR technology or not—you know, you just come in there, do your thing, and leave—not your office, then you can apply to us to be excluded from – exempted from the payment adjustments.

I mentioned the one thing that was special about the No. 4, and this is it: In the final rule, anesthesiology, radiology, and pathology, we went ahead and declared that those three specialties meet the criteria of lack of – of lack of traditional patient interaction, face-to-face and followup need. So we will just go ahead and use our administrative data that we have to give those anesthesiologists, radiologists, and pathologists an exemption. That data is your Medicare enrollment.

So, if you're an anesthesiologist out there or you're a radiologist or you're a pathologist, but you didn't select that as your primary specialty when you enrolled with Medicare, we will miss you when you – when we do this administrative data run. So be sure to check your Medicare enrollment prior to July 1st if you're an anesthesiologist, radiologist, or pathologist.

Hospitals—obviously, they don't have the scope-of-practice concerns with a hospital, so we're just looking at infrastructure. Again, new hospitals and CAHs, we'll know who you are. So hospitals are really looking at applying to No. 1, infrastructure, or No. 3, unforeseen circumstances.

Applying for those hardships—you know, I kind of went over which ones were which as far as applications: if you're a hospital, by April 1st; if you're an EP, by July 1st. We do not have the – we're not currently taking those applications. We will begin taking those applications no later than the beginning of next year. So we'll have several months to – between when we start taking them and the due date to get those in.

And, with that, I'm going to turn it over to David for Medicaid.

Medicaid-Specific Changes

David Koppel: Thanks, Travis.

Hi. My name is David Koppel. I'm one of the leads on the Medicaid HITECH team, and I'm going to go over some of the Medicaid-specific changes around Stage 2 and 2014 – 2013 and 2014, really.

So, starting on slide 67, the definition of what constitutes a Medicaid patient encounter has changed. Previous to 2013, only paid Medicaid claims could be counted towards a patient – towards a provider's patient volume. Beginning in – as of 20 – program year 2013, any encounter with a Medicaid-enrolled beneficiary can be counted towards a provider's patient volume and towards the patient volume threshold that a provider needs in order to be eligible for the Medicaid incentive program.

This includes zero-pay claims. For instance, if a beneficiary has exceeded their benefits for the year, or if a specific service isn't covered by Medicaid, those encounters can still be counted in the numerator.

The rule also provides some flexibility in the period that providers use to look at patient volume. Previously, the rule had been 90 days within the previous calendar year, and that was changed to any 90 days within the previous 12 months from attestation. And this allows new providers to attest sooner and get an incentive payment sooner, rather than having to wait until the next calendar year to be eligible.

Slide 68 – or – yes, slide 68: Again, this goes over the Medicaid encounters that – as I just went over them. Also, any programs that are Title 21–funded Medicaid expansions—that is, States that are not a separate CHIP but include CHIP in their Medicaid programs—those encounters can be counted in the Medicaid encounters for patient volume as well. They – CHIP encounters in separate Title 21 programs still cannot be counted towards patient volume.

Slide 69 is some examples of zero-pay claims that would be allowed in the patient volume calculation. And that's – again, slide 70 explains that CHIP counters – encounters for patients in Medicaid expansion programs can be counted.

Slide 72: In the rule, Medicaid made approximately 12 additional children's hospitals eligible, who had not had CMS certification numbers because they don't bill Medicare. And we created a process whereby those children's hospitals could apply for a dummy CCN that is only applicable to the EHR Incentive Program, and that allows them to then participate and get an incentive payment but not have to go through the whole certification process to get a CCN because they don't bill Medicaid.

The definition is that they have to be – it – separate children's hospitals, not a children's wing of a larger hospital. And this goes over – slide 73 goes over some of the details of how to get that number.

Changes to the hospital incentive calculation include some changes on where the payment amounts come from in determining the discharge-related amount instead of having to wait until the next fiscal year to use the previous fiscal year's data. We now allow States to calculate hospital payments using the most recent continuous 12-month period for which data are available. So if you apply in the – if a hospital applies for an incentive payment in July, they can use their discharge data from the previous June to the current June rather than having to wait for the – for the next fiscal year to apply.

Around clinical quality measures, in addition to the recommended core set that Maria mentioned earlier, there is also a pediatric core set of recommended measures. Again, these do not have to be – are not required measures, but they are a recommended set for pediatric eligible professionals, and – that we'd recommend they use. There are also additional behavioral health and oral health measures that we think specifically apply to Medicaid populations, and therefore to Medicaid providers, and we believe will be relevant to Medicaid providers' scope of practice.

Slide 76: Starting in 2014, we are aligning our definition of certified EHR technology around adopt, implement, and upgrade with the ONC Certification Standards. And the new definition is that a provider needs to have sufficient certified EHR technology to allow them to be a Meaningful User. This means that the – that providers don't necessarily need to have certified EHR technology to meet every core measure if they can apply for exclusions from those measures. So, for instance, if certain measures are outside of a provider's scope of practice, they no longer need to have the certified EHR technology to meet those measures. And, also, the – providers don't need to have EHR technology that can meet every menu measure, but only need to have enough so that they can attest to a sufficient number of menu measures to meet Meaningful Use.

We do encourage providers to think carefully about – when they buy an EHR, about what they're buying, because we would hate for a provider to not buy a system that can meet certain criteria because they believe that they will have an exclusion, only to find out after a year of, you know, trying to be a Meaningful User that they don't meet that criteria for an exclusion, and therefore will not be able to get a Meaningful Use payment, or an AIU payment for that matter.

Resources

Slide 77 points out some Stage 2 resources. There is a link to our website, where we have a lot of material about Stage 2 and what to expect, specification sheets, an overview, information about the 2014 clinical quality measures, the payment adjustments, and the changes in Stage 1 and comparing Stage 1 and Stage 2. So I encourage everybody to go to that website for more information in addition to using this slide deck for the information that's been presented here.

And I'll turn it back over to Diane. Diane?

Diane Maupai: David?

David Koppel: Yes.

Diane Maupai: So you're completed your part and we're ready to move on to Q&A?

David Koppel: Yes, we are.

Diane Maupai: OK. Well, sorry, everyone, for the reception problems we've had today. We've moved into another room with a new phone in hopes that will resolve the issue.

While I'm waiting for my other folks to come up and start Q&A, I want to make a special announcement.

Special Announcement

CMS is going to be providing an opportunity for Medicare-enrolled providers and suppliers to give feedback about their experience with their Medicare Administrative Contractor. That's the contractor that processes your claims, that handles your Medicare enrollment, that answers your inquiries, and some other things.

So on slide 78 you'll see a link where you can go and register, and we'll be selecting people to evaluate the MACs from those people that register on that line. So we would really like your feedback. It will help us improve the performance of our MACs and increase the efficiency of the program. So I hope you'll take a minute to register.

And with that, we're going to open the question-and-answer session, Victoria.

Question-and-Answer Session

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key.

Remember to 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 into the conference.

Please hold while we compile the Q&A roster.

Your first question is from Katie Golberg.

Katie Golberg: Yes. My question is around the online access in the patient engagement. So, are those two measures the same measures kind of put into one, so the patient engagement thing with the 5 percent that must send secure messages, and then the 5 percent of patients must access their health information? And is that 5 percent of the 50

percent who have accessed their information? Or is the 5 percent just the 5 percent of the patients that that provider has seen?

Travis Broome: It's 5 percent of the total. So, it's, you know – so, of the however many it is—thousand, or whatever, patients that the provider saw during the EHR reporting period, half of those need to have their information available, and then 5 percent of them actually need to look at it.

Katie Golberg: OK, so 5 percent of the total patients that he sees need to be accessing their information, and then that has nothing to do with the 50 percent. Correct?

Travis Broome: Right. Yes. So, if it was a thousand, he needs to make sure he's making the information available for at least 501, and making sure – and then 51 of the thousand need to actually access it.

Katie Golberg: Perfect. Thank you.

Travis Broome: You are welcome.

Operator: Your next question is from Dawn Ross.

Dawn Ross: Hi. My question revolves around critical access hospitals and the payment adjustments. We have this kind of theory that, you know, once you're on the Meaningful Use train, you have to stay on the train, but we have two critical access hospitals that are going to change EMRs. And that, in itself, does not qualify for a hardship, so we're evaluating whether or not those critical access hospitals should invest in their current EHR to meet Meaningful Use Stage 2, or wait until the change EMRs to then do that. If the payment adjustment doesn't happen until the same year, which in this case would be 2015, is there any penalty for them to not meet during 2014?

Travis Broome: Short of missing out on the incentive, no. Their 2015 payment adjustment will be based on their 2015 EHR reporting period year.

Dawn Ross: OK. That's what I thought. Thank you.

Travis Broome: Yes. And, you know, I would like to point out, while we can't – certainly can't prejudge applications on a call like this, the list of things in the rule is just that. It's a list of things we thought of then. If you have something else that comes up that you feel like is worthy, you know, feel free to submit applications. We've been approached by someone who switched vendors because they had some medication safety problems with their old vendor. Again, we can't – we couldn't pre-judge that situation, but we certainly encouraged them to apply even though that particular situation wasn't listed in the regulation.

Dawn Ross: Thank you. We'll apply and see what happens.

Diane Maupai: OK. Thank you, Travis.

Operator Your next question is from Leslie Witkin.

Leslie Witkin: Hi. This is Leslie Witkin at Physicians First in Orlando. I wonder if you could address EPs who are moving from group to group. Specifically, by way of example, I have a physician who is joining an existing group January 1st of 2014. And this particular group he is joining has attested to Meaningful Use their first year, 2013, and their second year for Stage 1 will be 2014.

The physician that is joining them is coming from another group, leaving that group. And that particular group has already done Stage 1 for 2 years, and so 2014, he would be technically Stage 2. Can you explain how EPs making moves like that – where they fall, specifically, example in the new group that he is joining, what he would have to do, what stage for Meaningful Use?

Travis Broome: I know this is very difficult for groups to do, but the easiest way to answer this question is just to pretend like there is no group, because there isn't – you know, the practice itself, the group or whoever employs this physician or partners with the physician – the – weren't even addressed in the HITECH Law. It's an individual incentive; it's an individual payment adjustment.

So, in your example, you know, taking the group out of it, that individual physician will be doing – needs to do Stage 2 in 2014. One of the – you know, to the extent we did anything to kind of help with that, there – certification of EHRs is not stage dependent. So everyone in the group's going to need 2014 certified EHR in that year. So the group itself – you know, because they're pulling that person in, doesn't mean they need a different certified EHR. They'd use the same EHR. It's just one of their members, this new person, is going to have higher Meaningful Use bars than others.

Leslie Witkin: And he would not be viewed as meeting some sort of exemption on a new physician?

Travis Broome: No.

Leslie Witkin: That exemption is for completely newly enrolled.

Travis Broome: Right.

Leslie Witkin: Is it possible for CMS to put out an FAQ about this topic? I don't think there is one. I could have missed it. But it's a question that keeps coming up. So if there was an FAQ, that would be great.

Travis Broome: OK.

Leslie Witkin: Thank you very much.

Operator Your next question is from Wayne Lewis.

Wayne Lewis: Yes. How are you doing this evening?

Travis Broome: Good. How are you?

Wayne Lewis: Doing all right. Just one quick question with two parts. From what I have heard earlier in other documentation, it seems that stage attesting in 2014 was going to be locked into quarters—January, February, March or April, May, June, or so forth. But from what I've heard on this call—say, for example, a provider could start February 15th and end their 90 days on May 15th—or I should say, 3 months—and attest at any time during that. They are not locked to beginning at the start of a quarter.

Travis Broome: So it actually depends. So, for a new – if they've never attested to Meaningful Use before, they always get that any 90 days whether it's 2015, 2014, 2013, 2016, whatever year it is. If it's their first year, any 90 days.

For the individuals who it's not their first year, in every year but 2014, they need to do a full year. In 2014, because of the need to get that upgraded technology we were just talking about, we do allow them, for Medicare, to work in quarters. It does need to be the quarter for our second year and beyond folks. But you work that quarter, not any 90 days. And that's in an effort to facilitate some of the alignments that Maria had mentioned with regards to clinical quality measurements, particularly on the hospital side, but both for EPs and hospitals.

So, in your first year, any 90 days; doesn't matter what year it is. After your first year, it's any – it's your full year, unless that year happens to be 2014, in which case, it's a quarter.

Wayne Lewis: OK. I just wanted to clarify that. I apologize, I didn't say 2014, that's what I meant specifically. But, you – it was said earlier in the call about attesting, say, 2 weeks prior to the October 1st. Would that be because somebody met Meaningful Use during April, May, and June and just not waiting until October 1st?

Travis Broome: Right. So, the October 1st thing was in regards to payment adjustments, and that's only applicable to the folks in their first year of Meaningful Use. So all the folks – everyone who's 2014 of Meaningful Use or later, they avoided that 2015 payment adjustment back in 2013.

Wayne Lewis: OK. And you can – if you were to attest in 2013 for Meaningful Use, that automatically exempts you from the payment adjustment in 2015?

Travis Broome: You got it. And then when you move in to 2014, we're looking at 2016 for your second year. And you can use any quarter in the year because, obviously, we'll have plenty of time between the end of 2014 and the beginning of 2016 to get that information across our systems.

Wayne Lewis: All right. Thank you very much.

Travis Broome: You're welcome.

Maria Michaels: This is Maria. I just wanted to add one more thing to that. On the EP side, specifically for clinical quality measures, if you wanted to use one of the reporting options for clinical quality measures for a program, such as the Physician Quality Reporting System, that has a 12-month reporting period, you would have to use that reporting period even in 2014 if you wanted to get credit in both programs for – with that one submission. So, that is kind of a one caveat there.

Beth Myers: But, that is – this Beth Myers from CMS, working – sitting here with Maria. But that is just for the CQM portion.

Maria Michaels: Correct.

Beth Myers: And too – I think there was one subtlety in your question that I just wanted to make sure that everyone heard. And that's that your reporting period if you're beyond your first year for Meaningful Use objectives is tied to the quarter in 2014, but you can attest anytime so – as long as it's after your reporting period. So you could have your reporting period be the first quarter and attest in September, if that's what works best for you. And, as Maria said, you do want to make sure that if you're doing one of the aligned programs that requires a full year of clinical quality measure data, that you do that data for that full year for the clinical quality measures only.

Operator Your next question is from LaChrissa Patrick.

LaChrissa Patrick: Hey. I just needed to make one verification. Going back to the 5-percent access on slide – sorry, I had this ready – 28, how will – who is monitoring how these patients are accessing this information?

Travis Broome: That'd be built into the certification of whatever technology you are using to make it available. So you have to use, you know, certified EHR technology. Some people use portals, some people use public health – personal health record vendors, some people use health information exchange organizations. But all those organizations, when they get certified, they, you know, have the ability, just like pretty much any website does, that when you log in, they know that you logged in, and they'll just give that information to you.

LaChrissa Patrick: So we need to verify with our certified EHR that that is a capability for them to monitor?

Travis Broome: Yes. As good diligence double-checking, it certainly doesn't hurt to test with them, or ask them and talk to them about how you want that to work and how it

works, et cetera, et cetera. But on the certification side, you know, they wouldn't even pass if they couldn't do that.

LaChrissa Patrick: OK. So they wouldn't pass certification. OK. And may I ask one more question just for clarification? Only the second year Meaningful Use reporters will go on to Stage 2? Second year and beyond?

Travis Broome: It's actually third year and beyond, so you get 2 years of each stage. So if you started – so the only people who will be doing Stage 2 in 2014 are folks who first attested either in 2011 or 2012. If you attested for your first year in 2013, you'll still be doing Stage 1 in 2014, and then you would move on to Stage 2 in 2015. You spend 2 years in each stage.

LaChrissa Patrick: Two years in each stage. OK. Thank you.

Travis Broome: You're welcome.

Operator Your next question is from Ann Lilly.

Ann Lilly: Hi. It's Ann Lilly with Ware Langhorne & Associates, and I just need a clarification. Slide 17, Stage 2 Meaningful Use, on the core objective No. 1, the 60 percent for medication and then 30 and 30 for laboratory and radiology. Can you elaborate on what is required for the laboratory and radiology?

Travis Broome: Yes. I mean, the denominator there is for laboratory orders and for radiology orders. The definition of what is a laboratory and radiology – we just adopted the definitions that are used for certification programs. They're in our information on our spreadsheet. They're a little long, and I don't – my memory is not quite that good to be able to recite them to you on the call. But they're defined, basically, using the – or existing regulatory definitions of those terms. Yes, so, it's – they're really three independent measures. And it's the orders on the bottom of each—so, medication order, lab order, radiology order.

Ann Lilly: Perfect. Thank you. And I just want to, I guess, one more time, make sure that we understand – I'm an MSO and have five platforms for certification and need to make sure that I understand. I have physicians at all levels of Meaningful Use stages of their EHR. If I have a new EHR implementer Meaningful Use this year—3 months, for example—next year, they'll still be on Stage 1. . .

Travis Broome: Yes.

Ann Lilly: . . . and do the – they can do 3 or 12 months—I'm promoting 12, obviously—but only 3 would be required, or that's 12 for Stage 1, or 3 for – 3 months for Stage 2 in 2014?

Travis Broome: So, someone who first attests in 2013 ...

Ann Lilly: Yes.

Travis Broome: . . . come 2014, their options are, like you said – you know, they could do a full-year reporting period if they got their technology on time, or they could pick a quarter in 2014. And they would be doing Stage 1 because they – you spend 2 years in each stage. If you add somebody in 2012, everything would be the same except they would have already done their first 2 years of Stage 1, and now they would be doing Stage 2.

Ann Lilly: So when we attest for Stage 1 for a year 2 in 2014, the system will know when we attest – your system will know what we're attesting for and therefore ask us the applicable questions for attestation for Stage 1, again in my scenario?

Travis Broome: Yes, because we obviously know how many times you've been in, or when you started the first time.

Ann Lilly: Perfect. Perfect. Great. Thank you.

Travis Broome: You're welcome.

Operator Your next question is from Lou Galterio.

Lou Galterio: Yes. Hi. I have a question, and I'm actually passing it on from a number of providers, and I want to make sure – I hope I'm saying it right, I think I am. And it has to do with the reporting of the clinical quality measures.

A couple of our providers go – I'm in the SunCoast RHIO, so we have providers who are members, and some of them practice independently in their own practice, and others go maybe part time in one place and full time in another place. So they may have their own EHRs that they've attested to, but when they go and practice on a part-time basis 1day a week, say, at a different office, there's a different EHR there that they would use.

So I guess the question boils down to, if a physician has attested to an EHR – and that's their EHR, but maybe they want to report quality from one of the offices they go visit which is a second and different EHR, as long as that, you know, that data is reconciled, can they report with more than one EHR for different functions?

Maria Michaels: Yes, they can. This is Maria. They can do so. We have yet to figure out how to do that really well with an aggregate-level file because you would have to essentially get a different aggregate-level file from each EHR, and then it's really not easy to combine the performance rates.

Lou Galterio: Yes.

Maria Michaels: So we would recommend that they do that using patient-level data until or unless we figure out a better way to do it with aggregate-level data. So, for example, using your example of the part-time EP at a couple of different sites and then maybe full time at one particular site, they would be able to get their EHR to create the Quality Reporting Document Architecture, or QRDA, Category I patient-level file from EHR No. 1, also then again from EHR No. 2, and then again from EHR No. 3. And then they'd just upload each of those patient-level files into the portal. So – and that way, we would end up having all of their data to compute their clinical quality report.

Lou Galterio: Thank you.

Maria Michaels: Sure.

Diane Maupai: OK. This is Diane. We have time for one final question.

Operator Your final question is from Patty Levin.

Patty Levin: I have two questions. The first one, I think, should be pretty easy. Surgery centers' facility fees—that's not part of this at all. Right?

Travis Broome: No.

Patty Levin: They're not a hospital. They're not a – OK. So we don't have to worry about that for surgery centers. OK. Then the other one has to do with the core objectives, the 17 core objectives. So my physicians are orthopedic surgeons.

Travis Broome: Yes.

Patty Levin: But the zero doesn't count anymore. How can we possibly meet these core objectives?

Travis Broome: I'm sorry, I'm not sure what you mean by "zero doesn't count." So, for the core, you know, there are still exclusions. Are you talking about the menu and how that's treated?

Patty Levin: Yes.

Travis Broome: All right. So . . .

Patty Levin: Yes.

Travis Broome: Even in the menu – so for the core, you know, you never could meet one out. And there are still several exclusions for many of them, although – I'm wondering, I guess, lab results? I'm kind of wondering why orthopedic surgery would be a difficult one. But the . . .

Patty Levin: Well, some of them, of course, we could do. But, I mean, some of them are irrelevant. A lot of them are irrelevant.

Travis Broome: OK. For the menu objectives – and, like I said, there are certain exclusions, you know, so if they do surgery, so obviously they're doing vital signs. But, you know, if – I'm trying to – anyway, we probably don't have enough time for me to hypothesize on that. But for the menu, there are exclusions. There are, for the EP results on all of them with the exception of two.

So if you look at the menu set, imaging results has an exclusion, although that might not be one you were interested in. Syndromic surveillance, cancer, specialized registry—all have exclusions. If I – so let's say I can only do family history and progress notes, which pretty much anyone can do—if I only do those two, then – and I meet the exclusion for the remaining four, I can still be a Meaningful User with the three out of six. I just have to meet the exclusions for the other. An exclusion doesn't – I can't meet the exclusion for one and ignore the rest.

Does that make sense?

Patty Levin: I don't know. I'm kind of really behind on all this stuff. Is there a way I can – we can talk to you, like, separately?

Travis Broome: Yes. You can send email – an email to, I'm sure, the email address Diane is about to give out, and we can get in touch.

Patty Levin: OK.

Additional Information

Diane Maupai: OK. It's nationalproviders – nationalprovidercalls – "calls" is plural – @cms.hhs.gov—nationalprovidercalls@cms.hhs.gov.

And unfortunately that's all the time we have for questions. I wanted to refer you to the resource slide, 77, which has a lot of good information on it. Remind you to sign up for the August 15th call on payment adjustments and hardship exceptions, another chance to get your questions answered.

An audio recording and written transcript for today's call will be posted on the MLN Connects Call website. We'll release – we will – excuse me – release an announcement in the MLN Connects Provider eNews when these are available.

On slide 79, you will see information and a URL to evaluate your experience with today's call—anonymous, confidential, and voluntary. But we hope you'll take a few minutes and evaluate your call experience. We do use it to improve our process.

Again, my name is Diane Maupai. I'd like to thank our presenters and also thank you for participating in today's call. Have a great day, everyone.

Operator: This concludes today's conference.

-END-