Centers for Medicare & Medicaid Services
Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs
National Provider Call
Moderator: Diane Maupai
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Contents

Operator: At this time, I would like to welcome everyone to today's National Provider Call on Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs. 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 Diane Maupai. Thank you, ma'am. You may begin.

Introduction

Diane Maupai: Thank you, Holley, and good afternoon, everyone, and thanks for joining us today. I'm 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 welcome you to this National Provider Call on Stage 2 Requirements for the Medicare and Medicaid EHR Incentive Programs. Today's national provider call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers.

During our call today, CMS experts will be discussing the final rule announced by CMS on August 23. This rule builds upon the initial progress of the incentive programs while introducing new criteria designed to improve patient safety and quality of care.

Before we get started, I have a few announcements. The link to the presentation was e-mailed to all registrants earlier this afternoon. If you didn't get that e-mail and you don't have the deck, please check your spam or junk mail folder for an e-mail from CMS National Provider Calls.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events page on CMS.gov. A direct link to the page where these materials will be posted was included in the e-mail that went out to registrants earlier today.

At this time, I'd like to introduce our speakers today. We have, from the Office of E-Health Standards and Services, Travis Broome. Travis is a policy analyst for meaningful use.

We also have Maria Michaels, a policy analyst for clinical quality measures at the Center for Clinical Standards and Quality, as well as Jason McNamara, Technical Director of Health IT at the Center for Medicaid and CHIP Services.

So I'd like to give you a feel for our agenda for today. Travis is going to start us off with an overview of the rule and say a few words about eligibility and then cover meaningful use.

Maria will be discussing clinical quality measures. Travis will come back to talk about payment adjustments and hardship exceptions, and then Jason will come on to discuss Medicaid changes. I will then open the line for your questions. And, with that, I'll turn it over to you, Travis.

Presentation

Travis Broome: Great. Thanks, Diane. So, yes, we'll go ahead and get going. For those of you who have the deck, the first two slides are just our title slides and our disclaimer about, you know, the presentation is current as of now. You know, it's not official stuff.

So slide 3, we – our – we usually call it the "Stage 2 of Meaningful Use Rule" or the "Stage 2 Final Rule," but there is a lot more in it than that, and we're going to be covering those things in this call, and I kind of went over those.

So the first thing we're going to really jump into is stage 2 eligibility, and you can see that kicking off on slide 6. Most of the eligibility criteria, primarily the "who", is already defined for us by law, so Congress did that for us – telling us, you know, which doctors, which specialists, which other provider types are eligible. So we really don't have any changes there.

The two areas CMS does have discretion over have to do with our hospital-based eligible professional definition, and I'm going to talk about that in just second, and then also the criteria to qualify for the Medicaid program, which Jason will talk about at the end.

So on slide 7 you're looking at the stage 2 hospital-based eligible professional definition that I mentioned. The law assumes that if you work primarily in a hospital, and we define "primarily" as 90 percent of the time, you're using the hospital's EHR, not your own and, therefore, that you are – the hospital is getting the incentive and not the eligible professional or doctor.

If that is not the case and you use – and you're an eligible professional who works in a hospital using your own certified EHR instead of the hospital's – so this isn't if you bring in your iPad and use that plus you use the hospital's, this is if you actually use your own EHR instead of the hospital's in the hospital. You – we allow for an application process. Basically, you tell us that, and then we will remove the hospital-based distinction, and you will become eligible for the incentives.

The next area we're going to spend some time on is stage 2 of meaningful use. If you go to slide 9, you'll see the – our plan for our progression of the stages. Meaningful use is the primary criteri[on] that you are required to do for earning the incentives, the other being clinical quality measures that Maria will talk about.

We came up with a staged approach for meaningful use. The first stage is really building that data foundation for the information in the EHR. Stage 2 is where we're at now, and that's really designing processes that actually use that data that we hope will lead to improved outcomes. And stage 3 is – I call it the "did we get it right" stage or "Do those processes that use the data that we collected actually improve outcomes?"

So on slide 10, you can see, for Medicare EPs, where you are on this path. And the most important thing to note – and this is for Medicare EPs, this is for Medicare docs, Medicaid docs, Medicaid other eligible professionals and our hospitals – the path is personal to you. It is your path, not everyone else's

path. So whenever you start meaningful use, you always start in stage 1. You always get stage 1 for at least 2 years, and then you will move on to stage 2, and then you'll get stage 2 for at least 2 years, and then you'll move on to stage 3, and so on and so forth. Again, driven by when you start, not by what year it is.

It is important to note, though, that once you start this ball rolling, it continues to roll. So if you were to skip a year – so let's say I started in 2013, and I did stage 1 in 2013, and I did it in 2014, but I wasn't able to do stage 2 in 2015, you would do stage 2 in 2016, and you would move on to stage 3 in 2017. So when you start is up to you, but once you start, it goes.

All right. The next two slides just – are basically the same thing for our Medicaid EPs and our Medicare and Medicaid hospitals. The important thing to note about Medicaid is you're allowed to – you have adopt, implement, and upgrade option. So not meaningful use for your 1st year – that does not start your stage progression.

So if I were to happen to do – let's say I did AIU this year in 2012, and I waited to start meaningful use until 2015, I would start in stage 1, and I would do stage 1 for 2015, stage 2 er 1 for 2016, and then I would move on to stage 2 in 2017. So you can have a gap between your adopt, implement, and upgrade year and your 1st year of meaningful use.

All right. So what is stage 2? Starting on slide 13, or 12: The changes from stage 1 to stage 2 pretty much represent a shift from the menu objectives to the core objectives. The total number of objectives, as you can see on the slide if you have it, remains the same, at 20 for eligible professionals and 19 for our hospitals.

All right, our next slide, talking about overall policies for stage 2, and really moving forward starting in 2014 regardless of stage, we only changed one, and that is how we treat the menu objectives. So, currently, if you go back to the last slide, you can see you had to do 5 out of 10 menu objectives if you're in stage 1. In 2011, 2012, and 2013, if you meet the exclusion criteria – which

is, you know, “I don’t prescribe medications, so therefore I don’t have to do drug formulary checks,” for instance – that would count as 1 of the 5.

Starting in 2014, it will no longer count as 1 of the 5, and you’ll essentially, if you meet that exclusion criteri[on], be doing 5 out of 9. And if you were to meet the exclusion criteria for 2, you’d be choosing from 5 out of 8, et cetera, et cetera, et cetera.

On the other side of the slide, you can see no changes. You still need to do eligibility criteria, you still need to have at least 50 percent of your outpatient encounters for an EP occur at locations equipped with certified EHR technology, measure compliance equals objective compliance, denominators continue to be divided into two buckets. One bucket is all the encounters at locations with certified EHR technology. The other bucket is only those for patients whose records are maintained in the certified EHR technology. If you go through our education materials, which bucket a measure falls in is identified for you.

More 2014 changes regardless of stage: So this first one is really something ONC did, not necessarily something that CMS did, regarding the certification of EHR technologies. ONC is requiring that everyone upgrade in 2014 to EHR technologies that have been certified to the 2014 final rule. In light of that, we are allowing providers to adopt 2014 certified EHR technology on a gradual basis, as opposed to all at once. So in 2014, regardless of stage, we have a special 3-month reporting period for Medicare EPs and for hospitals aligned with those fiscal and calendar quarters. For Medicaid EPs it could be any 90 days or 3 months, depending on the State. The reason we basically do that is so, like I said earlier, everyone does not have to upgrade on the same day.

The final overall policy I’m going to talk about is batch reporting. So this is, again, for our eligible professionals out there or docs. And starting in 2014 or at least no later than 2014, we’ll allow group practices to submit one file that still contains individual performance. So we still want to know how Dr. Smith did, not how the practice did. But the practice can put all of their doctors in

one file, give their individual data, and upload it, as opposed to going through the attestation Web site one by one.

All right. So now we're really going to get into the core here on slide 16, and it's the stage 2 EP core objectives. These – you have to meet all the core or an exclusion. I'm certainly not going to read all of these to you, both in the interest of time and the interest of, you know, maintaining your interest. I am going to talk a few bits about some of the objectives themselves.

CPOE – for those who don't know, it's Computerized Provider Order Entry. We have expanded our definition of "provider" and who can use the order entry function and have it count. It used to be any licensed health care professional. Starting in 2013 and beyond, it will be any licensed health care professional and certified medical assistants.

For e-prescribing we did bump the threshold from stage 1 up 10 percent. The other two things we did that aren't on the slide there is we did add an exclusion, again starting in 2013, for those eligible professionals who are in areas where there isn't a pharmacy within 10 miles that accepts electronic prescriptions. This is a very rare exclusion. We are only aware of – we're collecting a list of States where it happens, and so far, that list is North Dakota, Montana, and Alaska. But, certainly, if it applies to you, then it's available for you.

The other thing we're doing is, for those who prescribe controlled substances – these are usually your – you know, your high-powered painkillers and the like – it is possible to e-prescribe those, but it is not common, so basically we give the option—you can include them or not include them.

Everything else you see on this slide is really just kind of a logical progression from stage 1 to stage 2. You know, thresholds go from 50 percent to 80 percent. Clinical decision support interventions go from one to five—things like that.

So the – so on our next slide, there are two areas of stage 2 that really took big leaps on, and those are number 10 and number 15, care coordination and patient engagement. I'm going to talk about those separately.

So focusing on the other things here on the slide, again you'll see very natural progressions: office visit summaries moving to core; education resources, 10 percent; you know, medication reconciliation moving to core; immunizations moving from testing to successful ongoing transmission.

The important thing to note about our public health objectives is all the same exclusions do still apply. So if you are in a situation where your public health agency doesn't accept your immunization registry because you only do adult immunizations, and their's only child immunizations, then you are still meeting the exclusion. Similarly, if your public health agency doesn't do electronic submissions, you still meet that exclusion as well.

All right. So our next slide takes us to our menu objectives. So as you would suspect with the menu, you see a lot of new items here. Imaging results – the most important thing to know about imaging results are those two words "accessible through." This is not a requirement that every image you order from an imaging provider, a radiologist, or whoever becomes natively stored in your EHR. It just must be accessible through your EHR – you know, for example, using a link that links out to, say, the imaging center system.

Family health history, 20 percent; syndromic surveillance; cancers; specialized registry – all, you know, those public health registry and reporting requirements – again, successful ongoing transmission, but exclusions apply. So if you don't diagnose and treat cancer, then obviously, you know, you're not going to worry about cancer.

Specialized registries – you're really looking at only those registries in your specialty and in those that are sponsored by public health agencies, so it's not every registry in the world for every EP. And then we also included progress notes as well.

All right. For hospitals, I'm certainly not going to repeat the same things; I'll only highlight the differences. The only difference on the first slide, which is slide 20 on the deck I'm looking at, is electronic medication administration record is implemented and then used for more than 10 percent of medication orders. So you just take your denominator from your CPOE objective and rather than 60 percent, you're looking at 10 percent.

The important thing to know about this is really electronic medication administration record was really a process as opposed to a technology. When systems get certified, they're certified not only to support the process but also to provide an assistive technology for the process – bar coding, RFID – other examples that, you know, aren't necessarily as hardware driven. Those are the things we're really looking for you to use in terms of EHR technology in conjunction with what is a process in eMAR.

Next slide, on 20, there's really nothing to highlight here as far as significantly different from EPs. Please do note that all of the public health objectives did carry forward to core for hospitals – so immunizations, labs, and syndromic surveillance.

Slide 21, again, it's the hospital menu, so this is where the new stuff shows up. You know, some of it will look very familiar – imaging results, progress notes, family health history – all the same over from our EP menu. The three unique ones are:
Electronic prescribing. You add it for hospitals for those discharge medication orders. Obviously, when you're in the hospital, those will be dispensed by the hospital. For any scripts that are renewed, changed, or just flat-out new that are given by the hospital at discharge, 10 percent of those need to go through electronic prescribing.

Advanced directives—that was a stage 1 measure that we kept in the menu. The reason is simple: They – there are State variations as to whether or not an advanced directive kept in an electronic health record is actionable or not. And we wanted to ensure that – so if it's not actionable, that raises the policy question of whether or not it should even be in there, especially in an

emergent situation. We – in stage 1 we left that policy decision up to the hospitals, and we continue that policy in stage 2 by putting it in the menu.

And, finally, we added providing structured electronic lab results to ambulatory providers – more than 20 percent. And the important thing to note there is of *electronic* lab orders received.
So, basically, the denominator is those who you have a one-way electronic relationship with at least, and then the numerator is where you structure the results and utilize a bi-directional electronic exchange.

All right. I promised we'd take a closer look at patient engagement and care coordination, and so we'll do that now. So for patient engagements, there's two measures for view online and download of health information. The first is what I would call the very logical, natural progression of stage 1, and that is that goes to core and that we move to online access, whether it's through a portal hosted by the hospital with a provider, or a portal hosted by the vendor, a third-party portal like HealthVault – the, you know, the public health record or any other solution that's certified. All those are fine as long as they're certified. But it can make that information available online.

The second measures are highlighted there in the center of slide 22, and those are really the engagement measures. So we view that providers are in a very unique position to influence how much their patients engage in their health care and engage with the information about them that is available to them.

And to spur that influence, we came up with these two measures: More than 5 percent of patients must access their health information online, and more than 5 percent of patients must send secure messages to their doctor or eligible professional.

Our exclusions for these two measures: Based on the broadband availability in a provider's county, this basically allows for those who would have a very small denominator, because less than half of their people even have broadband, to be excluded from this.

All right. Moving on to 23, this is the care coordination, and you see a very similar structure here with a multi-measure objective, the first objective being a very straightforward – you know, from stage 1 menu moved into stage 2 core.

And to kind of give you an example of this, I'll use a personal example of mine. So the – I have a 20-month-old, and he got the magic number of ear infections in a row that earned him a referral to an ear, nose, and throat doctor. So when that referral was made, the pediatrician printed out a summary of care record, handed it to me, and said, "When you go the ENT, give him this." That would meet the 50 percent. That is providing a summary of care record at a referral.

It would not meet the 10 percent. The 10 percent is that the provider electronically transmits a summary of care for more than 10 percent, so we're going from 50 to 10, using the standards of certified EHR technology. So back to my same scenario, in this case, the pediatrician would either need to push or send that summary of care record electronically to the ENT using the standards that are included in the certification of EHRs. Or they would need to participate in a health information organization or exchange that would allow that ENT to pull it down. And when – if that ENT actually pulls it from the pediatrician, then that would count in the 10 percent as well.

And, finally, there is a third measure there, and this has to do with what happens if I can't talk outside of my network. We want to ensure that everyone can talk outside their vendor network. And when systems get certified, they almost always can. When you've got the lead programmer for the things sitting down with, you know, the crediting body, and they're working through the latest version, it always seems to work great.

But does it still work when it gets implemented in your actual practice or whatnot? And we go about proving this in one of two ways. The first is the way we expect everyone – most people, not everyone – most people will do this, and this is very simple. Go back to my example before—any one of the 10 percent. So if my pediatrician had sent it electronically, using CEHRT, to the ENT, and if he happened to know the ENT uses Vendor Y, and he knows

that he uses Vendor X—boom, he is done; he has met the third one. That can count as his one summary of care record in the 10 percent sent to a recipient of a different EHR vendor.

If it gets more complicated for you than that, move on to the next option for this one, and that is to test, using dummy data, with the CMS test EHR that we will make available to you. It does need to be a successful test, but you will be able to set it up with us and do that if meeting it the other way is any kind of burdensome.

So before turning it over to Maria, I'm going to really quick go through some changes to stage 1 here in the final rule. For computerized provider order entry, we're changing the denominator for stage 2 to the number of orders from at least – from the proxy denominator we used before, that you can see on slide 24 For our stage 1 folks, this will be optional starting in 2013 and beyond.

Changes to Vital Signs: We're adjusting the age limitations, as you can see on slide 25 basically getting rid of the age limitations for height and weight, increasing it for blood pressure from two to three to accommodate the latest clinical recommendations. We're also splitting the exclusion to allow providers to say that, "I collect height and weight, but blood pressure isn't important," or vice versa.

On slide 26 We're actually getting rid of the stage 1 objective and measure to test the electronic transmission of key clinical information. Simply that put the – with the stage 2 requirements we finalized, you're going to be testing, whether we require you or not, so why make you go through the trouble of actually attesting to it?

Changes to Electronic Copy: As I said before, ONC is requiring everyone to update their systems. As part of that update, e-copy is kind of going away as a criterion, and it's moving to the "view online, download, and transmit." So meaningful use stage 1 will be updated accordingly in – starting in 2014.

It's important to note that the 5 percent of patients actually accessing their information that I mentioned for stage 2 does not carry over to stage 1; only the 50 percent of patients having access to their materials does.

Next slide is for public health objectives, and really this is just a clarity purpose. We're adding some language to address some confusion where people didn't know what to do when they *could* submit information, but they weren't *required* to, and this is just basically saying, "If you can, for meaningful use purposes, you must. If you're prohibited, then, obviously, you're prohibited." And, with that, I will turn it over to Maria to go over CQMs.

Maria Michaels: Thank you, Travis. I'm going to go over to slide 31 and talk – start talking to you a little bit about CQM reporting in 2013. As you may have gathered, stage 2 will begin in 2014, so that means that in 2013 everyone will still be in stage 1. And so we're going to keep CQM reporting the same through 2013.

If you're an EP, what that means is you have 44 CQMs to select from, and you still will report through the schema of three core or alternate core, if you're reporting any zeroes in the – in the core measures, plus three additional CQMs. So you would need to report a minimum of six CQMs, and up to nine CQMs if you have any core CQMs that had zeros. If you're an eligible hospital or CAH, you have 15 CQMs and you must report all 15 of those.

In 2012 and expected to continue in 2013, we'll have two reporting methods available for reporting these stage 1 measures. One of them is attestation. All of you that have participated already would be familiar with this method. You would go online through the registration and attestation module and basically manually input what your EHR system – your certified EHR technology outputs. And what we're asking you to do is include exactly what your certified EHR technology gives you as an output.

The second method would be our e-reporting pilots, and we have e-reporting pilots on both the EP and hospital sides. If you are an EP, you can use the Physician Quality Reporting System EHR Incentive Program pilot. And if you're a hospital, there's an e-reporting pilot for eligible hospitals and CAHs.

If you're a Medicaid provider and participating through our Medicaid EHR Incentive Program, you would submit your CQMs according to your State submission requirements.

Slide 32, CQM Specifications in 2013: We're not going to be updating the electronic specifications for CQMs in 2013, again to try to keep it consistent and work towards upgrading all systems to include the specifications for the CQMs beginning in 2014. So those will remain the same.
As Travis mentioned earlier, ONC has allowed a flexibility in allowing providers to have systems implemented in 2013 that use the 2014 certification criteria that's listed in the ONC rule. So we're going to accommodate that as well, and if you are a provider that decides to implement a certified EHR technology, certified for the 2014 edition certification criteria, in 2013, you could report your CQMs via attestation. And the one caveat there is that the CQMs that you report have to be in both the stage 1 and stage 2 final rules.

So what that means for you is that if you are a hospital, all of your CQMs that you have in stage 1 would continue into stage 2, because all 15 that were in the stage 1 final rule will continue into stage 2.

If you're an EP, it's a little bit more complicated, but we're going to try to help you out here. We did propose and decided to finalize that three CQMs that were in stage 1 would be retired. We are – we have finalized that those three would not be allowable for submission in 2013 if you're using a system certified to the 2014 edition.

We list those here: That's NQF 13, 27, and 84. I would also point out that there are an additional 9 CQMs that we've decided to not move forward into stage 2 based on public comments, and we'll include those additional 9 in our – on our Web site so you can get more information about those. So there's a total of 12 that you would not be able to report if you decide to adopt your 2014 edition–certified technology early.

So slide 33: How Do the CQMs Relate to Other CMS EHR Incentive Programs? One of the – one of the things you may have noticed is that CQMs are no longer considered a core objective in the EHR Incentive Program,

beginning in 2014. What this really just means is that it's still required, you just don't have to check an extra box when you're going through your registration and attestation to say, "Yes, I'm going to be reporting my CQMs now" and move on to actually reporting them. You'll just go in and complete your attestation, or if you're using the e-reporting pilot you'll follow the instructions for how to submit your CQMs electronically.

One thing I would like to point out is that you still need to use the same EHR reporting period as your meaningful use measures. So if you're in your 1st year, for example, and you're using a 90-day reporting period for your meaningful use measures, that same exact 90-day reporting period must also be used for your CQM reporting.

Moving on slide 34, CQM Selection and HHS Priorities: We have named six national quality strategy domains, and those are patient and family engagement, patient safety, care coordination, population and public health, efficient use of health care resources, and clinical processes and effectiveness. Out of those six domains, your requirement would be to report CQMs that cover at least three of those domains, and we have the domains listed in the tables in the final rule to help you identify which CQMs go with which domains.

Moving on to slide 35, Aligning CQMs Across Programs: One of the things that we committed to all of you is that we would continue to try to align both CQMs and reporting methods in order to make it simpler for you to participate in all of our quality reporting programs.

And so, specifically with CQMs, what we tried to do was have the same CQMs used in multiple quality reporting programs beginning in 2014. And some of the programs that use some of the same CQMs include PQRS, the Hospital IQR Program, CHIPRA, Medicaid Shared – SSP, and Pioneer ACOs. So if you participate in any of those other programs, you would also have CQMs that apply in the EHR Incentive Program.

Slide 36: As I mentioned, we also are working towards aligning reporting mechanisms so that you can hopefully submit once and be able to participate

in multiple CMS programs. So we have started with a couple of things. For EPs, for example, we have tried to align the requirements for reporting with the PQRS program in this final rule. And, likewise, the physician fee schedule has included a proposal to do the same on the flipside. So the – in other words, the PQRS program EHR option would include similar, and hopefully the same, requirements for reporting.

The mechanisms to do this would be that you would, again, submit once and get credit for both programs. So I just mentioned, for an individual EP, that would include the PQRS EHR reporting options. And beginning in 2014 we're tried to include group processes in this, to make it a little bit easier for those practices that have multiple EPs reporting. So this would not be the same as batch reporting, because batch reporting includes individual EPs being sort of batched together and submitted. That is an option for your meaningful use measures as Travis mentioned. But what it would mean for group reporting and Clinical Quality Measures is that all of the EPs within the practice essentially submit as one organization, almost as if you're submitting as one EP. So all of your data would be pooled together to get the results for your CQMs that you submit.

We included two options for group reporting. One would be using the PQRS GPRO option, and the other would be using the – if you're part of an accountable care organization, an ACO. So either of the programs that CMS uses for accountable care organizations would be allowable for group practices.

On the hospital side, we're still working towards a way to completely align the programs. But the e-reporting pilot is actually a good basis for doing just that with the hospital IQR program. If you've paid attention to the inpatient prospective payment system rule, you would have noticed that they have put in that rule that we are expecting to have electronic reporting options in our hospital reporting program.

So participating in the e-reporting pilot before 2014 would be one way that you could get a feel for how that will be. We do expect that that pilot will be

the basis for electronic reporting in our hospital reporting programs beginning with the hospital IQR program.

Slide 37, Electronic Submission of CQMs Beginning in 2014: Beginning in 2014, all of the Medicare eligible providers that are in their 2nd year and beyond of demonstrating meaningful use must electronically report the CQM data to CMS. If you're in your 1st year, we would still allow attestation, and I'll get into a little bit about why that is in a second. But if you're in your 2nd year or later, you are required to submit your CQMs electronically.

If you're a Medicaid provider, you would, again, report your CQM data to your State, and that could include electronic reporting, but you would check with your State to make sure that you have the right information on that.

Slide 38, CQMs Beginning in 2014. One of the things that we did was that we have decided to keep the requirements the same regardless of what stage you're in beginning 2014. So whether you're in stage 1 or you're in stage 2, you would report from the same list of measures, and you would report using the same reporting schema. And that's true for both EPs and hospitals.

The complete list of CQMs that are required beginning in 2014 and their associated domains will be posted on our Web site in the near future, and it will also include, as I mentioned, that list of CQMs that were in the stage 1 final rule but were not finalized in the stage 2 final rule. So if you're an EP that would like to use your certified EHR technology, certified to the 2014 edition certification criteria, you'll have a good list of measures that will not be eligible for reporting in 2013.

We did also, for EPs, recommend a core set of CQMs that focus on our high priority health conditions and best practices for care delivery. I will point out that these core CQMs are not required to be reported, but we highly and strongly recommended that you report them. We have included nine for adult populations and nine for pediatric populations. And we tried to based our selections on, as I mentioned, high-priority health conditions and best practices, but also CQMs that could apply to a broad sort of variety, if you

will, or lots of different specialties, and hopefully we've been able to do that well for you.

Slide 39, a little bit more about the recommended core CQMs for EPs: We selected these based on several different factors, and these include conditions that contribute to morbidity and mortality of the most Medicare and Medicaid beneficiaries, conditions that represent national and public and population health priorities, conditions that are common to health disparities. Continuing on slide 40, conditions that disproportionately drive health care costs and could improve with better quality measurement, measures that would enable CMS, States, and the provider community to measure quality of care in new dimensions with a stronger focus on parsimonious measurement , and measures that include patient or caregiver engagement.

Slide 41, a little bit about some of the changes to CQM reporting from the stage 1 final rule: So prior to 2014, if you were an EP, I mentioned earlier, you would report a minimum of 6 CQMs out of the 44 finalized. And you would report 3 core measures, or if any of those were zeros, alternate core measures to replace the core measures that were with the zeros, and 3 additional measures or menu measures.

In 2014, if you're an EP – or beginning in 2014, you would be required to report 9 out of the list of 64 finalized CQMs. At least three of – at least three of the six domains must be covered in your selection of CQMs. So if you – out of the nine that you are required to report, at least three different domains must be represented in that group of nine.

And, again, I mentioned, we have recommended core CQMs, and there are nine of each for the adult and pediatric populations, and if those work for you, we highly recommend that you focus on those as a selection for those nine CQMs that you're required to report.

If you're an eligible hospital or CAH, your requirement prior to 2014 was to report all 15 out of 15 of the CQMs finalized in the stage 1 final rule. Beginning in 2014, hospitals would be required to report at least 16 out of 29

CQMs. And just as with EPs, the CQMs that you select must cover at least three of the six domains.

Slide 42, EP CQM Reporting Beginning in 2014: I'm not going to go through this particular slide in a lot of detail, but we wanted to include it so that you could get sort of a good summary overall of all the different kind of levels of information there are about the type of reporting. We've included sort of the category. So if you're, for example, an EP in your 1st year of demonstrating meaningful use, we include the information related to that. If you're beyond your 1st year, we've got all of your options listed. And if you're part of a group, we've got those options listed as well.

So I would encourage you to look at this slide. There is a lot of information on it, and I would be happy to answer any questions on that during the Q&A period if you – if you have them.

Likewise, on slide 43, we have similar information for Hospital CQM Reporting Beginning in 2014, and sort of the same format is there. If you're an eligible hospital in your 1st year, we've got your information there. And if you're a hospital that's in your 2nd year or beyond, then we've got your options available below.

One of the things I wanted to point out is that if you are in your 1st year of demonstrating meaningful use, one of the reasons why we list attestation as a way to submit your CQMs is because you have a deadline by which you have to submit your – all of your meaningful use data including your CQMs in order to avoid a payment adjustment in 2015.

So because of that deadline, we are allowing attestation so that you can submit – if you're an EP, you can submit your data by October 1st, and if you're a hospital by July 1st, in order to avoid the payment adjustments, and Travis will go a little bit more into payment adjustments shortly.

Slide 44, on CQM Timing: I just wanted to point out that we did not change any of the time periods for reporting CQMs from the stage 1 rule to the stage 2 rule. So, again, if you're an EP or a hospital in your 1st year of

demonstrating meaningful use you'd be able to use any 90 consecutive days within the year. If you're an EP, that's the calendar year, and a hospital would be the fiscal year. And then the submission period would be anytime following that 90-day period through the end of 2 months following the end of the full year. So, for an EP, that would be no later than February 28th of the following calendar year, and for a hospital that would be no later than November 30th of the following fiscal year.

If you're in your 2nd year and beyond, your reporting period would be one full year. So, again, for EPs that would be one full calendar year. For hospitals, that would be one full fiscal year. And, again, the reporting period would be the 2 months following the end of those years with the same final day.

I already mentioned that the main reason that we use attestation was to give you the opportunity or the ability to submit your CQMs by the deadline that's required in order for you to avoid a payment adjustment. So I'm going to sound a little bit like a broken record, but I did want to point out that that's a very important deadline for you if you are in your – in your 1st year in 2014, and actually all subsequent years beyond that.

And, finally, for CQMs on slide 45, we have a special CQM quarterly reporting period – it's actually meaningful use quarterly reporting period – in order to accommodate, as Travis described, this sort of roll into the 2014 edition-certified technology.

So for an EP, the calendar – the quarters match the calendar year, so we've got all of this listed for you there. And for the eligible hospitals and CAHs it will be the fiscal year. The submission period would remain the end of the full-year reporting period. So for EPs that would be January 1st to February 28th, and for hospitals it would be October 1st through November 30th.

And, with that, I will turn it right back over to Travis to talk to you a little bit more about payment adjustments and hardship exceptions.

Travis Broome: All right. Thanks, Maria. So we're going to go through this pretty quick, because there's essentially five questions that we have to answer for payment adjustments. And that's – the first one is, you know, who is affected? The second one is, how much are they? Third is, when do they take effect? Fourth, what do I need to do to avoid them? And fifth, are there any exceptions?

Congress answered the first three for us – the who, the how much, and the when – so there's not a lot to talk about there except to tell you what they said. And so we're going to spend our time on the – what you need to do and when you need to do it.

So on slide 46, it says at the top that it is a Medicare EP, subsection (d) hospital, or CAH. If you are not eligible for the incentive under Medicare, then you are not subject to the payment adjustment. It's the same definition of eligibility for both.

The payment adjustments – what you need to do to avoid it is to become a meaningful EHR user. Adopt, implement, and upgrade that I mentioned earlier is not meaningful use, wouldn't count. However, if you do – are doing meaningful use you can attest either to the Medicare or to the Medicaid program, if you're also eligible for the Medicaid program, and avoid the payment adjustment, assuming you do it on the timeline I will present, about half a dozen slides down.

All right. Slide 47 basically tells you the "how much" and the "when" that I mentioned. Again, (inaudible), there's not much we can do about that, to explain how this slide works. Say I am an eligible professional and I am subject to the payment adjustment in 2015, and I was also subject to the payment adjustment for e-prescribing in 2014. So that means my payment adjustment is 2 percent. So if I submit a bill for $100 to the part B physician fee schedule, I'm only going to get $98 instead of $100.

All right. So I already said, you know, what you need to do is meaningful use. Another important thing to remember about meaningful use, it's the same that – just like eligibility is the same – the definition of meaningful use is exactly the same whether you're going for the incentives or trying to avoid the

payment adjustments. You also use the same staged timeline, again, whether you use the incentives or the payment adjustments that we went into earlier.

We do use a prospective determination for Medicare EPs and our subsection (d) hospitals. The reason for this is two words: claims reprocessing. If we wait until after we start paying claims to make the determination, we will have to reprocess, or otherwise change claims in some way. You can imagine that becomes a very expensive proposition not only for CMS and the government, but also for the provider themselves because, you know, you have to update your accounting system, maybe you'd have to resubmit the claims. All these things add up real fast, especially when you're talking about one or a couple or just a few percentage points in the payment adjustment.

So if you are an EP who has demonstrated meaningful use in 2011 or 2012, then in 2013 you avoid the 2015 payment adjustment. Attest to meaningful use successfully in 2014, you avoid 2016; '15–'17'; '16–'18; et cetera, et cetera, et cetera.

On slide 48, if you attest to meaningful use in your 1st year of 2013—sorry, that's slide 49—then you would be also avoiding it in 2015 except using the 90-day reporting period, that same 90 days everyone gets in their 1st year. And then you'd be on the same full-year rolling timeline for all the other years: '14–'16; '15–'17; et cetera, et cetera, et cetera.

It is important to note that you must demonstrate meaningful use each year to avoid the payment adjustment. So if for some reason I don't demonstrate meaningful use in 2016, but I do in 2015 and 2017, unless I get a hardship exception, I would get the payment adjustment in 2018.

All right. Slide 50 has what we call, or what are sometimes referred to as the "drop dead" dates. So when is the last day I must attest to meaningful use successfully in order to avoid the 2015 payment adjustment? That day is October 1st, 2014, which means you must begin your 90-day reporting period no later than July 1st, 2014. Do not do this – you know, waiting for the last minute is never a good idea. Give yourself at least a month or more leeway to

make sure everything goes smoothly, and a small hiccup doesn't make you subject to the payment adjustment.

Slide 51 if you are eligible for both programs, as I mentioned, you can demonstrate meaningful use according to the timelines either to Medicare or to Medicaid.

All right. Subsection (d) hospitals, this is basically our IPPS hospitals. This slide here on slide 52 talks about the when and how much is the payment adjustment. You can basically read this slide as well as I can, but essentially it boils down to: Every year there is a payment rate update to the IPPS rates.

If you're subject to the payment adjustment in 2015, you would only get 75 percent of that update. 2016, you would only get 50 percent. 2017, you'd only get 25 percent of that update, and it caps out at 75 percent.

This slide probably looks very familiar. Hospitals – subsection (d) hospitals use the same rolling 2-year prospective determination. And on slide 54 they have the same drop dead date with the exception of – that it's moved forward because hospitals use the fiscal year instead of the calendar year. So that's July 1st, 2014; April 1st, 2014; again, do not do that.

Critical access hospitals on slide 55: This is – again, their "whats" and their amounts. Critical access hospitals don't do claims, they do cost reimbursements, and they get 101 percent of those costs normally. Under the payment adjustment over the next 3 years starting in 2015, they could lose that extra percentage point and up at just 100 percent.

All right. Slide 56: You heard me mention that critical access hospitals don't submit claims, so therefore there isn't claims reprocessing, and therefore there isn't the need for a prospective determination period. So for critical access hospitals, they do – we do use the EHR reporting period that's in the same year as the payment adjustment.

All right. That brings us to our fifth question, which is the hardship exemptions on slide 57. There are five categories of hardship exemptions. The

first three are basically the same for hospitals and EPs and have to do with things that really have nothing to do with meaningful use and certified EHR technology. And four and five are EP-only, and they have essentially everything to do with the way meaningful use is structured and certified EHR technology works and is being adopted.

So the first three – infrastructure, you know, insufficient Internet – and we're also well aware that, you know, being able to send an e-mail doesn't necessarily mean you have the Internet capabilities necessary for meaningful use and certified EHR technology.

New EPs – since it is a prospective determination, if you are a newly practicing EP, we obviously have to give you a grace period until you can catch up with the prospective determination. The determination is 2 years, so the grace period is 2 years.

Unforeseen circumstances – so your facility was flooded out by Hurricane Isaac, your vendor went out of business, you went bankrupt – you know, all those kind of unforeseen, uncontrollable circumstances that might prevent you from doing meaningful use for a given year.

Four and five. So for number four, lack of face-to-face or telemedicine interaction with patients and lack of followup need for patients: The important thing to remember for these two is it is possible for folks in this situation, for eligible professionals in this situation, to meet meaningful use. People have done it - radiologists have done it, anesthesiologists have done it, pathologists have done it.

However, it is – given today's current state of health information exchange, it is undoubtedly harder when you don't have the ability to collect information directly from the patient, and that makes you dependent upon others. Right now, given the current state of health information exchange, we judged in our final rule, that dependency, to raise to the level of what the law called a significant hardship. That might change as time goes forward, you know, maybe in the next rule cycle if HIE really takes off. But, for now, and until the regulation is updated, it is in place and does constitute a hardship.

The other thing has to do with EPs who practice in multiple locations. They may lack control over the availability of certified locations at locations that account for more than 50 percent of their encounters. If you remember from way back at the beginning, if you have more than 50 percent of your encounters at locations with certified EHR technology, we allow you to ignore the remainder. But if the – you have less than 50 percent, you're not eligible for the incentives, but we do have a hardship in here for you on the payment adjustments.

This is the classic case of, you know, surgeons who work a lot in ambulatory surgery centers, nephrologists in ESRD facilities, geriatricians, and other physicians who see patients in nursing homes. You do have – just working in those locations is not enough, you do have to demonstrate a lack of control. So if a group of surgeons own an ambulatory surgery center, it's unlikely they will be able to demonstrate lack of control. But, you know, if you they just work there, if they just operate there, then maybe they can do that.

Slide 58 is our – we do have three specialties who we judged to lack face-to-face and telemedicine interaction, or at least traditional face-to-face and telemedicine interaction with patients, and a general lack of followup need with patients. These specialties do not have to apply. They will be granted a hardship exemption if they have this as their primary specialty listed in PECOS on July 1st of the year before.

Hospitals, as I mentioned, they basically get the first three. So this is the infrastructure, the being new, and the unforeseen circumstances.

Slide 60 is a good reference for how to apply for the hardships. Like I said, with the exemption of hardship number four for EPs and radiologists, pathologist, and anesthesiologists, everyone needs to apply. Any EP can apply to any hardship exemption that they feel they meet the criteria for. However, you obviously do have to meet the criteria, like I gave the example earlier of, you know, actually have to lack control if you're a surgeon in an ASC, not …just working in an ASC is not enough.

All right. With that, I'm going to kick it over to Jason to close this out with the Medicaid-specific changes.

Jason McNamara: Thanks, Travis. I'm going to start here on slide 62 – I'm sorry, on slide 63. And so what we heard in stage 1 is that they really wanted – commenters really wanted us to lessen the provider burden and expand eligibility for the Medicaid EHR Incentive Program. So in carrying over with that theme for stage 2, we've attempted to do that here, and I'll talk about it in the next couple of slides.

Moving on to slide 64, one of the bigger parts to the Medicaid expansion for us really was under the stage 1 rule. Currently, we looked at services that were rendered on any specified day where Medicaid may have paid for either part or all the services. We included part of the services, to include any co-pays, cost sharings, or premiums. Providers found this to be challenging to dissect, essentially, their encounters based on if Medicaid had paid for some of the services.

So in stage 2 – and this will be applicable to all stages starting in year 2013, the participation year – we are no longer looking at the encounter. And we are looking at Medicaid-enrolled individuals regardless of the payment liability. And a big thing here is that we've included zero-paid claims and encounters with patients that had been funded through title 21.

Going on to slide 65: We include some examples in our regulation of what zero-pay claims could include, and these are general experiences. A claim could have been denied because the beneficiary has simply maxed out the service limit, the service simply wasn't covered under the State Medicaid program, or the Medicaid agency has paid a zero-dollar amount because maybe another payer has contributed to the overall service costs, or simply the claim was denied because the claim wasn't submitted in a timely fashion in accordance with State regulation.

And what we are proposing – excuse me, what we have implemented – is that these types of scenarios can now be included in the numerator for patient volume and eligibility for the Medicaid EHR Incentive Program.

Moving on to slide 66: You heard me talk a little bit about CHIP, and CHIP encounters can now be included in patient volume. Previously, under the stage 1 rule, we really only looked at CHIP encounters restricted under the title 19 Medicaid expansion programs. Now for stage 2 and applicable to all stages in 2013 participation year, CHIP encounters can now be included for all title 19 and title 21. The important note here at the bottom is that any of your standalone CHIP programs cannot be included in the Medicaid patient volume calculation, and this has stayed consistent with stage 1 and stage 2.

Slide 67: One of the other parts where we tried to expand eligibility in our program was the essential lookback period for our patient volume calculation. Currently, under our stage 1 regulation, Medicaid patient volume was calculated across a 90-day period in the previous calendar year for eligible professionals or the previous Federal fiscal year for eligible hospitals. Essentially now, in stage 2 – and this applies to all stages in year 2013 participation year – States have the option to allow providers to calculate Medicaid patient volume across a 90-day period within the last 12 months preceding the provider's attestation date. So this is an either/or option here.

This also applies to the – our needy individual inpatient volume group, and we've also expanded the patient panel method, with at least one Medicaid encounter occurring within the previous 24 months versus the 12-month period which was in stage 1.

Slide 68: Hospital payments are restricted to CMS certification numbers. We inadvertently, in developing our policy, excluded approximately about 12 children's hospitals around the country. This had to do with the fact that they don't – simply don't bill Medicare, so they don't have a CMS certification number. And what we are proposing – or what we have implemented, excuse me – on slide 69 is that those hospitals can now be included in receiving a Medicaid EHR incentive through a proxy of sorts for the CCN.

Moving to slide 70: This is for the Medicaid hospital incentive calculation. In stage 1 we used some very esoteric language that basically allowed hospitals – using discharge data from the hospital fiscal year that ends during the Federal

fiscal year prior to the hospital fiscal year that serves as the 1st payment year. That was administratively burdensome to the providers and hospitals. We recognized that, and so in stage 2 and starting in Federal fiscal year 2013, hospitals that enter our program can simply use discharge data from the most recent continuous 12 months for which data is available prior to the payment year. This also aligns us with the Medicare calculation as well. And I think I'll turn it back over to our moderator.

Diane Maupai: All right, thank you, everyone. You'll see on slide 71 that we have a page with a lot of stage 2 resources. On slide 71 you'll see a link to that page, as well as a number of the educational products that are on there.

And before we move to Q&A, we're going to pause for a minute to complete keypad polling so that CMS has an accurate count of the number of participants on the call with us today. There'll be a few moments of silence while we tabulate the results. Holley, we're ready to start polling.

Polling

Operator: CMS greatly appreciates that many of your minimized the government's teleconference expense by listening to these calls together in your office using only one 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 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.

Diane Maupai: While we're waiting…

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

Diane Maupai: While we wait for that compilation to be done—and this is Diane again—I'd like to introduce Rob Anthony, who's joined us for the question and answer session. He is our expert on EHR incentive programs in the Office of E-Health Standards and Services.

Operator: Please continue to hold while we complete the polling. Thank you for your participation. We will now move into the Q&A session for this call.

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 in the conference. Please hold while we compile the Q&A roster.

Diane Maupai: This is Diane again. Let me take a minute to remind everyone that this call is being recorded and transcribed. Before asking your asking, please state your name and the name of your organization. And in an effort to get to as many questions as possible, we ask that you limit your questions to just one. If you'd like to ask a followup question or have another question, you can press star 1 to get back in the queue and we'll address these additional questions as time permits.

Question and Answer Session

Operator: Your first question comes from the line of Paula Crout.

Paula Crout: Hi. My name is Paula Crout. I'm calling from Minden Dermatology, and that's in Minden, Nevada.

My question is, in our practice, we have two doctors. We attested for stage 1 in October and December of 2011. So my question is, when do I re-attest for the calendar year 2012?

Maria Michaels: OK. This is Maria. I'll go ahead and take that.

Paula Crout: Thank you.

Maria Michaels: I thought Travis was going to jump in there. So if you're an EP practice, your data capture portion, I guess, of your EHR reporting period is the full calendar year, and you would then attest during the 2 months following that full year. So that would be January 1 through February 28 of 2013 for the year – for the EHR reporting period collected during 2012.

Paula Crout: OK. But what if I reported it in 2011?

Maria Michaels: You couldn't have reported it in 2011 because your data would have to be collected during January 1 through December 31 of 2012.

Paula Crout: But I did register it for the incentive program. The first one I created on – let's see – because we've already received our first incentive payment.

Travis Broome: Right. So the way it works – this is Travis, I'm trying to jump in. So in 2011, it sounds like you – if you received your incentive payment, you did your 90-day reporting period …

Paula Crout: Correct, yes.

Travis Broome: … in 2011. So that means you move onto full-year reporting periods for 2012.

Paula Crout: OK.

Travis Broome: So for 2012 your reporting period, as Maria pointed out, will be January 1st all the way through December 31st, and then after December 31, 2012 you have the first 2 months of 2013 to report.

Paula Crout: OK. So January and February of 2013 I need to report for the – for the calendar year 2012?

Travis Broome: That's right.

Paula Crout: OK. Yes, thank you.

Travis Broome: You're welcome.

Diane Maupai: Thank you, Travis.

Operator: Your next question comes from the line of Mitchell Richman.

Mitchell Richman: Yes. Mitchell Richman, Surgical Specialists of New Jersey. My question pertains to, in stage 2, what will be core measure 15, the transitions of care. As surgeons, generally, we receive these patients, so there are rare occasions when we refer to a completely different provider, so I understand it will be – that will be the encounter that counts. But what if, say, the primary sends them to us, and we say it's not a surgical problem, and we refer them back to their primary for further care? Is that considered a transition of care?

Travis Broome: No. If you're basically declining a referral, the fact that you declined it isn't – wouldn't count as referring them back.

Mitchell Richman: OK.

Travis Broome: Since you didn't provide, really, care for them, yes.

Mitchell Richman: Well, no. I'm saying – we said it's not a surgical problem, so go back and see your doctor.

Travis Broome: Right, right.

Mitchell Richman: OK. Thank you.

Diane Maupai: Thank you, Travis.

Operator: Your next question comes from the line of Stephanie Miller.

Stephanie Miller: Hi. It's Stephanie Miller from the physicians network with Huntsville Hospital in Alabama, and I'm wanting to understand what you were saying as far as – I know once we start our – we will be attesting in just a few months for our first 90-day period, and then our first 365-day measurement period will be in 2013. In the event that you – let's say, you know, we have our first 90 days in 2012, we did not meet it in 2013 or did not do an attestation for 2013, and we – and we make it in 2014. Are you saying that 2012 was a stage 1. We would start – we would have, again, stage 1 in 2014, and if that is the

case, is the incentive dollars the same as it – does it go $18,000 and then $12,000, or do you forfeit that, the $12,000, or how does that work?

Travis Broome: All right. So under Medicare, you – since I'm assuming that's what you are referring to, your situation, $12,000. So once you start your ball rolling in Medicare, it keeps rolling without you – or with or without you, both in terms of the money and the stages of meaningful use.

So if you do stage 1 meaningful use in 2012 for 90 days, but for whatever reason you're unable to meet stage 1 meaningful use in 2013 for the full year, come 2014 you will need to be doing stage 2. And you will have missed the payment in 2013. For our Medicaid folks on the line, since (inaudible) made the distinction, I'll say for them too that meaningful use stages work the same way, but the money is more flexible.

Stephanie Miller: And if you do AIU – if we do AIU in 2012, you – I believe that you said that there could be a gap – that you do not actually have to do your 90 days until possibly until 2014?

Travis Broome: Absolutely. So in our same situation, if rather than stage 1 of meaningful use in 2012, you did AIU in 2012, come 2014 you – so you didn't do anything in 2013 – in 2014, you would do 90 days of stage 1 meaningful use.

Stephanie Miller: OK.

Travis Broome: And then your ball would start rolling.

Diane Maupai: Thank you, Travis.

Operator: Your next question comes from the line of (Jessica Drapish).

(Jessica Drapish): Yes. (Jessica Drapish). I'm with Associates in Gastroenterology. I kept hearing – you were saying or somebody was saying about – submitting the CQMs. Is that the same as attesting, or is that a completely different step as attesting?

Maria Michaels: This is Maria. Attestation is one way you could submit your CQMs up until 2013 if you're in any part of stage 1. Whether it's your 1st year or not, you could use attestation as the means by which you submit your CQMs. Another method you could use is one of our e-reporting pilots, as I mentioned, and that would be an electronic method of submitting them.

Beginning in 2014, the only time you would be allowed to submit your CQMs through attestation is if you're in your 1st year. And the reason we did that was in order to allow you to submit them before the end of the year in order to not miss that deadline for payment adjustments. And, again, if you were an EP, that would be October 1st and hospitals, it would be July 1st.

If you are in your 2nd year or beyond in 2014 and you are reporting CQMs, you must report them electronically. And that would be through some sort of method—for example, a portal where you would go through and submit your Clinical Quality Measures through that. It would not require manual entry. There would be sort of an electronic transmission of those results. Did that clear it up?

(Jessica Drapish): Can you explain to me what an e-reporting pilot is?

Maria Michaels: Sure. So what we have tried to do in order to make sure that both CMS and the provider community kind of have a testing ability before we actually require electronic reporting, we've set up pilots on both the EP and the hospital sides, where you would submit your CQMs according to the requirements through these electronic methods. In this case, there is a portal method in both the EP side and the hospital side. On the EP side, it's through the Physician Quality Reporting System. And on the hospital side, it's kind of a standalone currently that we have available through QualityNet. And we're expecting to use both of those pilots as the basis for the electronic reporting that begins in 2014.

So if you go through your registration and attestation and do your meaningful use measures and objectives, you come to the part where you're ready to do your CQMs, you will see that you have an option to do either attestation or an e-reporting pilot. And if you select the option for e-reporting pilot, then it will

take you to where you would need to go in order to submit your CQMs electronically.

(Jessica Drapish): Thank you.

Diane Maupai: Thank you, Maria.

Operator: Your next question comes from the line of Marilyn Pinckney.

Marilyn Pinckney: Hi. My name is Marilyn Pinckney, and I'm with Cardiac Study Center in Tacoma, Washington. My CEO has a concern about stage 2 core objective number 13, where it says more than 5 percent of patients send their – send a secure message to their EP. A lot of our patients are still – what we would consider elderly and maybe not used to using a computer system to converse with their physicians. Is there any workaround on this?

Travis Broome: Well, there isn't a workaround, but that very reason is why it's 5 percent as opposed to, you know, 20 or 30 or 50 or something like the other objectives. So, you know, we did think about that and then went back and forth and got a lot of public comments on whether to try and create a whole bunch of workarounds and then go with a higher percentage overall. But we decided it was much simpler just to go with a very low percentage of 5 percent.

Marilyn Pinckney: OK. Thank you.

Operator: Your next question comes from the line of Carol Bishop.

Carol Bishop: Hi. This is Carol Bishop calling from the Pennsylvania Medical Society, and I would just like a little bit of clarification on the submitting of the CQM reporting data in 2014. I listened in on another presentation regarding stage 2, and what was presented at that webinar was a phrase that said you may not submit your CQM data for 2014 quarterly reporting until the – I'm sorry, until January or February of 2015, regardless of what quarter you're reporting on.

Now, my understanding is, for example, if a practice did their first 90 days of stage 1 in 2011, did their full year 2012, doing their bonus year 2013 of stage 1, then doing their first 90 days which must be in conjunction with a calendar

quarter in stage 2. And let's say they do the second quarter of 2014 and then they do their attestation. When do the CQMs get reported?

Maria Michaels: So I'll just point out that the calendar quarters that you're referring to are for those that are in their 2nd year or beyond. If you're an EP in your 1st year, you would have the – any 90-continuous-day period, as you did in stage 1. So I just wanted to make that clarification off the top there.

It is true that if you are reporting your clinical quality measures in 2014, where we're allowing those calendar quarters in order to accommodate the transition to upgraded certified EHR technology, you won't be able to report it or to transmit or submit those CQMs until after the end of the full reporting period, and for EPs that is January 1st to February 28th. For hospitals, in case there are hospitals listening in, that is the end – or the 2 months following the end of the Federal fiscal year. So that would be October 1st through November 30th.

Carol Bishop: So then should the practices hold off on doing their attestations until January or February of 2015?

Maria Michaels: No. Because your EHR reporting period would still be the same. So your meaningful use measures and objectives would be still that second quarter – if that's the one that you've selected to report on – and you can go ahead and attest those. The important alignment, if you will, of the EHR reporting periods is the time that you collected the data.

Carol Bishop: And how would the incentive payment be distributed then?

Rob Anthony: It would be distributed after the complete submission of information, so it will be distributed after, obviously, attestation information for meaningful use functional objectives are put in, and then after the clinical quality measure data is submitted.

Carol Bishop: OK. Thank you.

Diane Maupai: Thank you, Rob.

Operator: And your next question comes from the line of Darlene Lackey.

Darlene Lackey: Yes. This is Darlene Lackey with Arkansas Health Group, and my question is about the anesthesia hardship request, when that information will be on the Web site with the process and the form to apply for the hardship?

Travis Broome: Well, the – you know, the anesthesiologists, if it's your primary specialty, won't have to apply. For those who are seeking to apply, we'll have that information up in the near future. But the applications aren't due until July 1st, 2014.

And for all of the hardships except, you know, the last two, the circumstances have to occur in either 2013 or the first 6 months of 2014, so it's not a particularly high priority right this second. But they will certainly be up well, well, well before they're due in July 1st of 2014.

Darlene Lackey: OK. Thank you.

Travis Broome: No problem.

Operator: Your next question comes from the line of (Jason Waldren).

That question has been withdrawn. Your next question comes from the line of Jordan Tannenbaum.

Jordan Tannenbaum: Hi. Jordan Tannenbaum from Fox Hospital in upstate New York. I just wanted to clarify, if you're on the Medicaid side – EP side – if you did AIU in year 1; in year 2, when you're first attesting to stage 1, you just have to do a 90-day attestation even though you did AIU in the 1st year?

Travis Broome: That is correct.

Jordan Tannenbaum: OK. Thank you.

Diane Maupai: Thank you, Travis.

Operator: Your next question comes from the line of Luz Elena Garcia.

Luz Elena Garcia: Hi. This is Luz Elena Garcia from El Paso Pulmonary, and our question has been answered. Thank you.

Operator: Your next question comes from the line of Beverly Moffatt.

Beverly Moffatt: Hi. This is Beverly Moffatt from Exempla Healthcare in Denver. I would just like to confirm, please, that the Medicaid HMO days will be included in the calculation for the Medicaid 10 percent data criteria.

Jason McNamara: Are you referring to the hospital calculation, or are you referring to the patient volume calculation?

Beverly Moffatt: Sorry. The patient volume.

Jason McNamara: So we look at – basically, we look at any – if only the beneficiary was covered, whether that's an HMO or direct bill, they will be included in the numerator.

Beverly Moffatt: OK. Thank you.

Jason McNamara: You're welcome.

Diane Maupai: Thank you. We have time for one more question.

Operator: Your next – or you final question comes from the line of Shelly Trotter.

Shelly Trotter: Hi. I'm Shelly Trotter, and I'm calling from Heartland OBGYN. And I guess my question is, I'm a little confused. We are EP. We have qualified for Medicaid only, and we have done the AIU stage, and then we did our 90-day attesting in 2012 this year. And so do we start by calculating 365 days, like January 1st, 2013, and then would attest in 2014? Is that the way it is?

Travis Broome: That's correct.

Shelly Trotter: OK. I think then that answers my question. And can you skip a year there if you need to – if like, you can't measure that first part of the year because your EMR is not ready yet? How does that work?

Travis Broome: Sorry. Could you repeat the question again real fast?

Shelly Trotter: Well, if you – like if your EMR wasn't ready in time by January 1st, 2013, and maybe it was June, can you start your 365 days in June and then go until June of the following year, or do you…

Travis Broome: No. The reporting period is fixed, basically, under the assumption that you will have already attested for 90 days of meaningful use already. So, you know, the idea that the EMR would go down or become unavailable after 3 months of use is not really something that we allow for, because I haven't really heard of it happening.

Shelly Trotter: Well, I guess my thinking is that, you know, it's certified now. But for the stage – for this next stage it's not – they might not have all the things implemented … .

Travis Broome: Well, right. That gets back to the beginning of my presentation. In 2014 which is when, you know, stage 2 will become available, for that very reason, we instituted a special reporting period that is only 3 months long. So in that case, you would have more time in 2014 for that very upgrade reason you were talking about. But for the other years when there – the certification upgrade isn't going on then there's – then you would need to be ready on January 1st.

Shelly Trotter: OK. So – I'm still just a little confused, I'm so sorry. But – so are you saying that we would still go ahead and attest for that full year, and then in 2014 we would do the 90-day thing?

Travis Broome: Right. Because you don't have to upgrade certified EHR technology to the 2014 criteria in 2013, and – but you do in 2014. So you could potentially go 90 days a year, 3 months a year.

Shelly Trotter: OK. So then there's an extra year thrown in there where you will get a payment by attesting? Is that what you're saying?

Travis Broome: Well, I mean, you get one payment per year.

Shelly Trotter: Right. OK. I'm just – I'm sure I'll figure it out.

Travis Broome: Sure, sure. Yes. And, basically, it is possible to kind of be in this weird situation, so this is our 2012 folks, right? Where you do a 90 days, you go to a full year, and then you go back to 90 days, and then you go back to a full year. And you will get one payment per year. So you will get – you know, for those four attestation periods, two of which are a full year and two of which are 90 days, you would get four payments total.

Shelly Trotter: OK. So when we apply – or do this year we would not have to – we would not have – we're just – we would report the 365. So when you report the 365, if you start that January 1st, then when do you – when do you attest then?

Travis Broome: You attest the first 2 months in the following year. So for 2013 you would attest in either January or February of 2014.

Jason McNamara: Just to throw something else in there: You said that you're a Medicaid-only group, right?

Shelly Trotter: Yes.

Jason McNamara: Yes. So you might want to check with your State, because we've allowed States some flexibility with the reporting period. But, at minimum, Travis is correct that there will be a 60-day tail period. In some situations there are longer though, so we would ask that you consult with your State.

Shelly Trotter: OK.

Additional Information

Diane Maupai: Thank you so much, Jason and Travis, and thank you all for joining us today. That's all the time we have for questions. We suggest that you look at the EHR incentive programs page at CMS.gov for a lot of information there. And you could also, if you can't find your answer, call the EHR information center. That number is 1-888-734-6433.

On the last slide of your presentation you will find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. Registrants for today's call will receive a reminder e-mail

about the opportunity to evaluate the call within two business days. If you've already evaluated the call, just disregard that e-mail. We appreciate your feedback.

Again, the audio recording and written transcript will be posted to the National Provider Calls and Events page on the CMS Web site soon. Again, my name is Diane Maupai. It's been my pleasure to serve as your moderator today. I'd like to thank Travis Broome, Maria Michaels, Jason McNamara, and Rob Anthony for their participation in today's call. Have a great day, everyone.

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

END