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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Office Hours for Eligible Profeassonals in Stage 2 of Meaningful Use
MLN Connects National Provider Call
Moderator: Diane Maupai
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Contents

This transcript was current at the time it was published or uploaded onto the web. Medicare policy changes frequently so links to the source documents have been provided within the document for your reference.

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Operator: At this time, I would like to welcome everyone to today's MLN Connects 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. Hello everyone. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore. I'm happy to serve as your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on Stage 2 of Meaningful Use for Eligible Professionals under the Medicare and Medicaid EHR Incentive Programs. MLN Connects Calls are part of the Medicare Learning Network.

Eligible professionals who have completed at least 2 program years under Stage 1 of Meaningful Use in the Medicare and Medicaid EHR Incentive Programs are required to meet Stage 2 criteria starting in 2014, which is the first year of Stage 2 implementation.

Today's call will be conducted in the form of an office hour session, providing a concise overview of Stage 2 requirements, reporting options, and data submission processes, followed by an extended question-and-answer session, which will include a live Q&A with our experts as well as responses to some of the questions submitted by participants in advance of today's call.

Before we get started I have a few announcements. You should have received a link to the slide presentation for today's call in previous registration emails. If you have 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 slide – at the left side of the webpage, select "National Provider Calls and Events," then select the May 29th call from the list. Please follow along with those slides as we present today.

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 these are available.

At this time, I would like to introduce our first speaker, Minet Javellana, who is the Eligible Professionals Clinical Quality Measures Project Lead in the Center for Clinical Standards and Quality at CMS. So with that, I turn it over to you, Minet.

Presentation

Minet Javellana: Great. Thank you Diane. And on slide 4 you will find the agenda. As Diane mentioned today, the National Provider Call will be conducted in the form of an office hour session, meaning that we will give a brief presentation on the Meaningful Use

Stage 2 requirements, options for reporting Clinical Quality Measures, and data submission. However, one of our primary objectives is to answer your questions about reporting for Stage 2 of Meaningful Use as an eligible professional. So we intend to leave plenty of time for the question-and-answer portion of today's call.

During the Q&A we will address many of the questions that you submitted in advance of this call. And we will also allow time for a live question-and-answer session during which you will have an opportunity to ask questions of the CMS experts we have with us today.

Please note that this office hour session is targeted to eligible professionals participating in Stage 2 of the Meaningful Use and the EHR Incentive Program. So we will be speaking to those requirements specifically and we will not be addressing requirements for eligible hospitals or critical access hospitals participating in the program.

So to get started, on slide 5 you will find the speakers. I would like to introduce our experts for today's session who are listed. Diane has already introduced me, I am Minet Javellana and I'm the Clinical Quality Measure Project Lead – excuse me – for Eligible Professionals for the EHR Incentive Program. I am happy to be here with you today to provide an overview of Stage 2 of Meaningful Use.

Tim Jackson is also here with us from the Center for Clinical Standards and Quality. He is the National Level Repository Liaison and he is going to talk to you today about options for reporting Clinical Quality Measures and how you may report one to meet multiple reporting requirements.

Brahma Sen is the Physician Quality Reporting System, or PQRS Release Manager, and he will be talking to you today about the process of submitting quality data through the PQRS portal to meet Meaningful Use reporting requirements.

We also have with us today Beth Myers and Tom Romano to help address your Stage 2 questions – questions. Beth joins us from the Health IT Initiatives Group within the Office of e-Health Standards and Services. And Tom is from the Centers for Medicare & Medicaid – I'm sorry – Centers for Medicaid and CHIP Services.

Overview of Stage 2 of Meaningful Use

So we will start with slide 6, overview of the – of Stage 2 of Meaningful Use. Now we're on slide 7, the goals for stage 2 Meaningful Use. So after attesting to Meaningful Use for at least two reporting periods in Stage 1, eligible professionals will move to Stage 2. We will cover some of the more specific differences between Stage 1 and Stage 2 reporting requirements on the next slide. But the important thing to communicate here on slide 7 is how the Stage 2 criteria support the overall goals of Meaningful Use.

One of the primary goals of the EHR Incentive Program is to promote the use of electronic health records in ways that can positively impact patient care. As you know, there are three stages of Meaningful Use, each having its own criteria. For Stage 1, the criteria focus on gathering and sharing data in a structured way to promote usability, while Stage 2 criteria focuses on those using data to advance clinical processes. For Stage 3 criteria, this will be more on demonstrating improved outcomes through the use of EHR technology.

The most important thing to know about Stage 2 is that its objective seeks to foster the use of EHRs to help improve care and outcomes, as well as reducing cost and saving lives. Stage 2 criteria seeks to achieve those goals by placing an emphasis on clinical decisions support, care coordination, and patient engagement.

On slide 8 we are comparing Stage 1 and Stage 2 requirements. As you know, there are two parts to demonstrating Meaningful Use and qualifying for incentive payments under the EHR Incentive Program in any stage. Providers must attest to Meaningful Use objectives and they must also report a certain number of Clinical Quality Measures, or CQM. Since 2014 is the first year that eligible professionals can attest to Meaningful Use for Stage 2, most of you should already be familiar with these requirements for Stage 1. So this slide is intended to highlight the changes moving into Stage 2.

Along the left side of the graphic you see that you'll see – you will still be reporting 20 total objectives in Stage 2, but now there are 17 core objectives that are required and you must select an additional three of six menu objectives to complete the requirement, with the idea being that you will select the three that are most appropriate for your practice –particular practice.

Many of these objectives in Stage 2 will be familiar to you from Stage 1. To progress to Stage 2, some objectives that were in the menu set in Stage 1 have been moved to the core set for Stage 2 and are now required for all providers. Some objectives that were in the core set in Stage 1 now have higher thresholds that you must achieve in order to demonstrate Meaningful Use in Stage 2. And there are also some new Stage 2 core and menu objectives.

The Meaningful Use Stage 2 final rule that was published in September 4, of 2012, provides the Clinical Quality Measure reporting requirements for all eligible professionals in any stage of Meaningful Use starting in 2014. In 2014, all eligible professionals must report nine CQMs, which must be from at least three national quality strategy domains. But there are few different options for how these measures are reported. In the next section of this presentation Tim Jackson will go into more detail about the different reporting options for Clinical Quality Measures that you see listed for Stage 2 on this slide.

For more information about the Stage 2 objectives, you may visit CMS' EHR Incentive Programs Stage 2 webpage and download the specification sheets for eligible professionals. We'll provide that link at the end of the presentation. Likewise, you may visit the EHR Incentive Program Clinical Quality Measures webpage for more information about the 2014 CQM requirements and specifications for the measures.

On slide 9, this will introduce us to the PQRS reporting option. So as an eligible professional participating in the EHR Incentive Program, many of you may also participate in the Physician Quality Reporting System, or PQRS Incentive Program. Slide 9, you will see that it is possible to report Clinical Quality Measures one time to meet reporting possible Medicare quality program. In 2014, eligible professionals may register and report through the PQRS system to satisfy the CQM component of Meaningful Use. This is option 2 that you saw on the previous slide.

I will now turn it back over to Diane.

Keypad Polling

Diane Maupai: Well thank you, Minet. At this time, we’re going to pause for a few minutes 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 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.

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

Presentation Continued

Meaningful Use CQM Reporting Options

Diane Maupai: OK thank you. This is Diane Maupai, I’m going to turn the presentation over to Tim Jackson, who’ll take a deeper dive into CQM reporting options for the EHR Incentive Program. Tim, please go ahead.

Tim Jackson: Thank you Diane. In this reporting section of the presentation, we are going to touch briefly on the different reporting options for Meaningful Use in 2014 and special 2014 reporting requirements.

If you turn to slide 11, you'll see a table laying out three different reporting options for Clinical Quality Measures to meet Meaningful Use requirements in 2014, reporting specifically for the EHR Incentive Program using the PQRS EHR reporting option or using a group reporting option. The important thing to note on this slide is that all of these reporting options leverage the PQRS portal that you can access through QualityNet. Data submission through QualityNet will be covered in greater detail in the next section of the presentation. But for now, let's compare different reporting options.

As Minet described earlier, to meet Clinical Quality Measure reporting components of Meaningful Use, you must report nine CQMs from three different domains. And while CMS recommends a core set of CQMs for both adults and pediatric populations, you may all select the nine measures that best fit your practice and work flows. For the EHR Incentive Program, these measures reflect your entire patient population, regardless of payer. And you will submit the measures in aggregate through the PQRS portal on QualityNet according to the required reporting period for 2014, which is 1 calendar year based on quarters.

The second option that you may leverage to meet Meaningful Use quality reporting requirements is to report CQMs in order to satisfy PQRS reporting requirements using certified EHR technology, CEHRT, or for data submission vendor that uses CEHRT. In the slide notes, eligible professionals who select this option will be subject to the reporting periods established for PQRS EHR reporting option, which is 1 full year of data. So in order to meet the PQRS requirement in 2014, you would submit the full 2013 calendar year of data for each CQM you are reporting. You will also submit this data via the PQRS portal on QualityNet.

Lastly, there are two group reporting options that can satisfy the Clinical Quality Measures reporting requirements for the EHR Incentive Program. Eligible professionals can meet these requirements either through satisfying requirements, through pioneer Accountable Care Organizations participating or comprehensive primary care initiative participation using CEHRT or similarly the individual PQRS reporting option. Eligible professionals may report as part of a group under the group practice reporting option or GPRO or PQRS using CEHRT. Again, both of these options require a 1-year reporting option and leverage the PQRS portal on QualityNet for data submissions.

We now turn to slide 12 for Meaningful Use CQM reporting in 2014. If you select the first reporting option and submit CQM specifically in accordance with the EHR Incentive Program requirements in 2014, you will only need to submit data for one quarter of the year, meaning a consecutive 3-month period that is aligned with the calendar year quarter, such as January to March, April to June, and so on. And this is regardless of whether you're in Stage 1 or Stage 2 of Meaningful Use. This is a special circumstance in 2014. For all other years of participation in the EHR Incentive Program with the exception of your first year attesting to Meaningful Use, you will need to report 1 full year of data regardless of stage.

However, the Office of the National Coordinator establishes a new set of EHR certification standards for 2014 and requires that all EHR Incentive Program participants adopt certified EHR technology that meets these standards in order to meet Meaningful Use requirements. So in order to give EHR vendors a chance to update their systems and obtain certification in accordance with 2014 requirements and to give eligible professionals the opportunity to adopt the updated technology, CMS instituted the 3-month reporting period for Meaningful Use in 2014.

At this point, I'm going to turn it over to review data submission and hand off to Brahma.

Data Submission

Brahma Sen: Thank you Tim. Good afternoon everybody. By way of brief introduction, the Physician Quality Reporting System data submission process allows healthcare providers to submit patient-held data based on the requirements for the Clinical Quality Measures. For the purpose of today's discussion, we'll focus on how PQRS portals can be used to support submission of CQM data for measures using the EHR Incentive Program for eligible professionals.

Moving to the slide 15. We talk about here what are the type of data that can be accepted in the PQRS portal. There are different formats in which data can be submitted. Quality reporting document architecture 1 is used by the EHR for EPs to stand the approach to submit patient-level data. QRDA1 is standard SO7 TDE format updated to PQRS needs.

Summary data can be submitted using QRDA3, which is also based on the SO7 standard CDO format. But there are additional summary specifications – PQRS-specific that are registered some of the certification and QCDR that is qualified clinical data registry specification also available to submit summary data. There are both certificates and data that can be submitted using maintenance of certification program XML specification. Additionally, there are GPRO Web interface examples of specification available by – for submission by the GPRO group practice reporting option individual entities to submit patient level data.

Moving on, slide 16. What we show here is a graphical representation of all the different applications available in the PQRS portal. There are three applications available. One is submission engine validation tool, submission application, and GPRO Web interface. To access the PQRS portal, a user must have an IACS account. The user is then authenticated to the Enterprise Identity Management System upon entry to the portal in order to access these applications for PQRS data submission.

Moving on to the slide 17.We are introducing different terms particularly in terms of the participants and programs associated with the PQRS program. The Eligible Professionals Group Practice Reporting Option and Accountable Care Organization individuals can submit data to the – in the PQRS portal. Supporting entities such as registry, data submission vendor, electronic health record vendors can also submit data to the PQRS portal. And they all can submit data on behalf of various programs such as PQRS, CPCI, MOCP, and HITECH-Meaningful Use.

Moving on to the slide 18, we delve a little bit deep into the different submission methods. First, we have Submission Engine Validation Tool. Submission Engine Validation Tool is used for testing the file format and content prior to submitting for the production submission. This is available around the year and this can be used by – we have different types all for the QRDA1, registry, QRDA3, and MOCP type of specification SEVT tool can be used.

Data for incentive eligibility and payment adjustment can be submitted to production submission or GPRO Web interface. For production submission, link is available between typically from January to February or January to March, depending on the year. Data is collected and passed to the measure engine for processing an incentive calculation and payment adjustment from the production submission or GPRO Web interface.

Moving on to slide 19. In this slide we want to give a brief overview of the key terms of the submission process. The first thing happens in the portal is user authentication and authorization. So we authorize – authenticate for the user can upload a file to the PQRS system. Upon receipt of which, those data is parsed and validated and stored for measure and incentive calculation and further feedback reporting.

Slide 20. In this, we want to take you into a little bit and talk – into the subsystems of PQRS system. So from a high level, we have PQRS portal as a component. We have authentication and authorization component. And then we have the integration engine, which essentially receives and validates the data which is stored in the submission database. And then the content is stored in the warehouse database. And obviously we have the validation and statistics report component associated with the PQRS submission system.

Moving on to slide 21. Here we saw the interaction of various entities and individuals and the data submission type that interacts with the PQRS portal. Eligible – for example, if you look at below top – upper rows, we have eligible professionals, GPROs, and GPRO or ACOs. They can use any of – and then the row – second row, we have MOCP, EHR, direct registry, and data submission vendors. The eligible professionals can use any of the methods to submit data to the PQRS portal.

For example, eligible professionals can submit data directly from the EHR system using QRDA1 specification. They can also submit data to registry using registry XML specification. Similarly, a GPRO can use a registry to submit data or they can go to using the Web interface XML specification to submit data. So these are just some of the examples of how the data from different individuals and supporting entities falls into the PQRS portal system.

Moving on to slide 22, we saw here the high level SEVT flow. I have noted about the purpose of SEVT is to check the data format prior to submitting data for incentive eligibility and payment adjustment process. The user can submit one file at a time and receive the real time feedback on their data submitted. When accessing the portal, the user is authenticated and authorized before accessing the Submission Engine Validation

Tool. After entering the SEVT, the user can upload the file, which is then validated. The user will receive a success message if the file is valid or errors and warnings if there are some errors in the file. And obviously, they can correct those mistakes and resubmit to get proper feedback. Once the user receives the success message, the user may upload another file and you can continue as many times. And like I mentioned before, this SEVT component is available around the year.

Moving on to slide 23. Here we're showing the submission component of the application. Once the user is ready to submit data in the program, they can log into the portal to submit data that is used for payment and incentive eligibility purpose. For the production submission activity, the user can select one file or multiple files. So if it is one file, then you upload one XML file or you can combine or compress in a zip multiple files and submit as one zip file.

After the file is processed by the backend system, an email – an email is sent out with status of each file – status against each of the files in the zip file. The user can then run the summary – a detailed report that provides information about errors encountered for each of the files submitted. And then the user will have opportunity to correct the error to resubmit for acceptance by the PQRS system. This PQRS application is used – can be used for QRDA1, QRDA3, registry, MOCP, and QCDR type of data.

In your presubmitted questions, some of you inquired about batch uploading. The system does accept batch file submissions. The user can upload a zip file, as I've told you before, consisting of individual submission files in the PQRS portal. The PQRS system will send out an email after all the files in the GPRO process with a valid – a valid status for each of the files in the zip. The user can also run reports to learn about the status of their submission. Depending upon the number and the size of the file submitted in a batch, it is important to note that feedback on files may take some time.

This concludes our presentation on data submission. And I'd like to turn things back over to Diane.

Presubmitted Frequently Asked Questions

Diane Maupai: Thank you, Brahma. At least at our end, it looks – it sounds like the speakers are coming in and out. We're checking on that. This is Diane. Thank you, Brahma and to all of our speakers. We'll now transition to the question-and-answer portion of this office hour session. The remainder of our time together will be spent answering your questions about the Stage 2 of Meaningful Use, the reporting options, and data submission process for reporting.

As you may recall, when you registered for this event you were given an opportunity to submit – to email questions to us. We're going to begin this Q&A session by addressing some of your presubmitted questions. We appreciate the overwhelming interest in this session. And based on the number of participants, we have on the line and on the number of questions we received in advance of this call, there's no way we could possibly address each question individually during this session. So we've selected the top five topics or themes that came up frequently in your submissions. We'll provide a general response to the top five presubmitted questions and include some illustrative examples that we hope will address many of your individual inquiries.

After we go through those five questions and responses, we'll open the lines to take questions from the audience. If we're unable to get to your question today, either not covered by the top five questions or in our open session, we'll provide some additional CMS resources at the end of this call. And I want to let you know that we've reviewed all the questions and we'll consider them as we develop and update future educational material.

And at this time, I'd like to turn things back over to Beth Myers, who will address some of your frequently asked questions about Stage 2 of Meaningful Use.

Elisabeth Myers: Thank you. Hi, this is Elisabeth Myers from CMS. I just want to go through the top five questions. And you can see quite a bit of information on the slides that you were able to access but I'll talk through a little bit and sort of give you a perspective of each one.

The top question was actually about the system, related to registering for the system – for the program and then actually going to the attestation process. And this has been a question that we've gotten a couple of different times outside of this forum as well so we did want to make sure to go ahead and answer.

Eligible professionals register by the Medicare and Medicaid EHR Incentive Program Registration and Attestation System – it's a big long name but it's one system – in your first year only. However, I do want to make sure that we are highlighting that last bullet on your slide that talks about updating – is it the last one that talks of updating? Oh, no, I'm sorry, it's the second bullet on your slide that talks about updating your information. We do need you to go back in anytime that you have some changes to your contact information or the email address or any of the information within the system that you registered for the program. If you do want to make sure that that is always kept up to date because that is how we contact you.

So you only register for the program once and then you have an active registration in our system. Then each year you would come back and attest to your Meaningful Use data. So in your first year, you would register and then when you were done with your Meaningful Use reporting period, you would use the Registration and Attestation System to attest to that data. And then each subsequent year, you would come back in and use the system to attest to that year's data.

Again, keeping in mind that if any of your contact information or basic information about your practice changes, you need to come back in and update it because, again, that contact information in that system is how we reach out to you if we need to reach you.

So the second slide is talking about – I'm sorry, we're on slide number 26, the second question. If an eligible professional attested to Meaningful Use for the first time in 2012, but for some reason did not attest in 2013, what stage does the eligible professional attest to in 2014?

We get this question quite a bit as well. So, again, we wanted to make sure that we get the answer out to you all. There is a difference between Medicare and Medicaid for this – what you see on this slide relates directly to Medicare. Medicare is consecutive. Once you begin your first year of Meaningful Use, the clock keeps counting. So even if you skip your second year, it was still your second year. So if you begin your first year of Meaningful Use and successfully attest to your data in 2012, in 2013 it would be your second year, whether you actually participated or not. And then in 2014, you would be beginning Stage 2.

Again, if you begin in 2012, whatever you do in 2013, you would be moving to Stage 2 in 2014 having had 2 years at Stage 1, whether you successfully attested or not since you began your first attestation. So the clock for Medicare keeps going on.

In Medicaid, you can skip a year. Progression along the EHR Incentive Program, again, it's based on that first year of attestation. So the same applies if you work – if you do your first year in 2013. And then maybe you do 2014. If you skipped in 2015, that would have been your first year of Stage 2 so you would do Stage 2 in 2016 as your second year of Stage 2. So once you started the timeline from Medicare, you continue throughout, even if you skip a year.

Next slide. The third top question that we got is about new participants. And there's actually two pieces to this question, and since we got sort of variations on it, we sort of combined them into one so we can answer both. There are two types of new participants. There are brand new eligible professionals who have never practiced medicine before. And I want to set them to one side. And on the other side, you have new participants to Meaningful Use. So those are existing providers who may have been practicing medicine for years but have not participated in the Meaningful Use program before.

In either case, if you have a group practice, for example our group practice that's listed on the question that has a group of providers who have all completed 2 years of Stage 1. So they did Stage 1 in 2012 and in 2013 and they hire someone new, whether it's a new participant or a new professional – eligible professional overall, so someone who's new to medicine. Do all physicians including the newly hired physician report for Stage 2 in 2014?

And the answer is no. The program is designed for each provider individually. So each provider may have their own track or their own participation scheme for Meaningful Use. This means that if a provider moves from practice to practice, their Meaningful Use Stages go with them. And that the same applies if you have a group practice. So you have a new provider who's been a provider for a while but hasn't done Meaningful Use before. That new provider in the first year they are participating in your practice would begin

Stage 1 year 1of Meaningful Use. And then they would progress in accordance with their own participation timeline, regardless of what everyone else in your practice is doing.

Now that group that are brand new providers, that are just new to practicing medicine that I said we'd set aside for a second, they are also automatically granted a hardship exception for their first year of practice. So what that means is they can of course to go ahead and start Meaningful Use if they're able to do so and they can get on the track for incentive payments and they can begin their progression through Stage 1 for 2 years and then begin Stage 2 after 2 years.

However, they are also granted this automatic hardship exception for the payment adjustment. And that means that we understand very well that if you're a brand new practitioner and have never practiced medicine before, it might be difficult for you to onboard into the program. So that particular case applies to brand new practitioners not necessarily to new participants. But again, each provider starts their own track of Meaningful Use and progresses along it at their own speed.

Next slide please. We are on slide 28, question number four of the top questions that we're submitted. If an eligible professional first attested into Meaningful Use in 2013 but does not participate in 2014, what would the penalty be?

So, there are quite a few things going on with this question. And there's a lot of confusion around how this works. And it is a little bit complicated when you think about it in – and look at it as a – as a big whole. So what really matters is trying to figure out how it applies to you. So, payment adjustment – where we adjust the overall payment for Medicare claims, for Medicare EHR Incentive Programs – so this was put into practice by the Congress. So Congress put payment adjustments in the original act that made the program. And we have developed the regulation that helps to implement it.

So what the payment adjustments say is that if you do not meet Meaningful Use, you will be subjected to a 1 percent per year – and cumulative after that if you do not meet Meaningful Use. So that is a 1 percent payment adjustment to your Medicare claim.

However, there are a couple of things that make this a little bit confusing. So the payment adjustments begin in 2015. But that doesn't mean that that has anything to do with Meaningful Use in 2015. In order to be able to implement this effectively, we actually had to offset the year. So 2013 is the year of Meaningful Use, so that's the EHR reporting period that relates to the 2015 payment adjustment. So if you first attest – to successfully attest to Meaningful Use in 2013, that means that you are not subjected to a payment adjustment in 2015.

Let me repeat that. If you complete Meaningful Use successfully in 2013, you are not subjected to a payment adjustment for 2015. However, if you do not meet Meaningful Use in 2014, you could be subjected to a payment adjustment in 2016. So that's how it works, it's always a 2-year offset from the year of Meaningful Use.

So in this particular example, if you do – if you attest to Meaningful Use in 2013 but you do not successfully participate in 2014, you would receive a 1 percent payment adjustment to your 2016 Medicare claim. If you successfully attest to Meaningful Use the following year, you would no longer receive a payment adjustment. If you do not meet Meaningful Use again the following year, you would then get a cumulative payment adjustment in 2017. So that's how it works. It's offset 2 years by what you – when you participate in the program.

And, again, if you meet Meaningful Use in either Medicare or Medicaid, you would not be subjected to the payment adjustment.

Next slide please. So we're on slide 29. Question number five of the top questions that were asked. If an eligible professional has applied for a hardship exception but finds they are able to successfully attest to Meaningful Use for the reporting year, is there anything special that they need to do?

And the answer is no. Again, those payment adjustments that we just discussed, you can apply for a hardship exception if you believe that there was a reason that is a legitimate reason – and the categories are listed on our website to explain what the various categories are – that you can apply for a hardship exception to be exempted from the payment adjustment. As we already mentioned, an example of a reason that you would be exempted is a brand new eligible professional – someone who has never practiced medicine before, they don't even have to apply. They are given an automatic exception to the payment adjustment.

However, if you apply for a payment adjustment, hardship exception – use the application and apply for a given year, there's absolutely no reason that you couldn't go on to meet Meaningful Use if your circumstance has changed. And that could be either in the subsequent year or within the same year. So if you apply for a hardship exception, let's say for 2014, you could then go ahead after you've already submitted that application even if that application has been accepted, and then your circumstances change and you discover that you are in fact able to meet Meaningful Use after all, you can go ahead and attest to Meaningful Use and receive an incentive payment.

So I do want to encourage you if you do apply for a hardship exception and you do discover that you can meet Meaningful Use, there is nothing else that you would need to do. You did not have to withdraw your application. You do not have to notify us. You can just go ahead and log into the Registration and Attestation System and attest for your Meaningful Use data.

And that is the last of the top five questions that we have. Again, we did group them into categories to try and broadly cover what you all had asked. There were different nuances for each of you. I do encourage you, if you have further questions on those, feel free to ask them. But you can also look on our website for a lot of this information.

Diane Maupai: Well thank you, Beth. So I'd like to thank you again for submitting your questions in advance to this session and hope that the top five managed to address many of your inquiries.

Question-and-Answer Session

Our CMS experts will now take your questions. But before we begin, I'd like to remind everyone that the call is being recorded and transcribed. Before asking your question, please state your name and the name of the organization. In an effort to get to as many of your questions as possible, we ask that you limit your question to just one. If you would like to ask a followup question or have more than one question, you may press star 1 to get back into the queue and we'll address additional questions as time permits.

Alright, Victoria, we're ready to take our first question.

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 the background noise will be heard into the conference.

Please hold while we compile the Q&A roster. Your first question comes from the line of Sandra Pogones.

Sandra Pogones: Yes hi, this is Sandy Pogones from Primaris. During your presentation on 2014 attestation, you did not mention whether – you didn't mention the ability to attest to the eCQM for this year. I understand that that option is still available, that you can either attest or submit electronically, is that correct?

Elisabeth Myers: This is Beth Myers from CMS. Yes, that is correct. You may attest to the CQMs or you may submit them electronically for dual credit for the program.

Sandra Pogones: Thank you.

Operator: Your next question comes from the line of DeeAnne McCallin. DeeAnne, your line is open.

Your next question comes from the line of James Semmens.

James Semmens: Hi, this is James Semmens, HIT Project Manager for Evansville Primary Care. I appreciate your presentation today. My question is in regards to the CQM data submission. Medicaid EPs, we are in phase 2 of Medicaid attestation. It is my understanding that CQM data will be uploaded to the state. What are my options in regards to that besides the group option?

Tom Romano: Hi, this is Tom Romano with CMS. And so, yes, for the – for the Medicaid program, CQM data must be submitted to the state. And we leave it essentially to the states to sort of determine how the CQM data gets to them. So, I think in a lot of places – in a lot of cases, it will be attestation. But there also might be electronic options available or HIE options, depending on the state. So that's something that, you know, might vary from state to state so you would want to check with the – with the – with the program for your particular Medicaid program.

James Semmens: Thank you.

Operator: Your next question comes from the line of Sherry Tutor.

Sherry Tutor: Hi, this is Sherry Tutor from Central Florida Medical Care. And one of my questions and concern is on the Meaningful Use Stage 2 is one of the core measure is for patients to be able to communicate through a practice portal. And the one thing when they set these core measures up, of course they did for everyone. So we live in a community where 80 percent of our patients are 65 and plus. Ninety percent of our patients don't have computers, don't want computers. And it's going to be very difficult for us to meet that core measure.

So my question to you is, we've done incentives to get the patients to try to sign up for the practice portal that we have. We have put incentives out there for them, and they're just not interested. And we give them the information and, you know, to get one of their family members to sign them up, whatever it takes, and they're not interested.

Elisabeth Myers: So, we've heard this before. This is Beth Myers from CMS. We certainly heard this concern before, that is why the threshold is only 5 percent. We had proposed a significantly higher threshold.

Sherry Tutor: Yes.

Elisabeth Myers: And then through the public comments we …

Sherry Tutor: Yes.

Elisabeth Myers: … received, there were a number of comments suggested a lower threshold. There was a supportive measure but a much lower threshold, which is why the threshold is 5 percent.

Sherry Tutor: Yes.

Elisabeth Myers: Anecdotally, and I am not recommending that anyone go out and do all of these things, but anecdotally we have heard from provider groups who have come up with innovative ways to work through this, including actually assisting the patients in logging on and seeing their information so they understand what they can do on the portal.

Sherry Tutor: That’s correct. And we’ve done the same thing.

Elisabeth Myers: In recommendation if anyone – there’s no specific recommendation for anyone to follow a specific course but that is why that particular measure has a 5 percent threshold. And in addition, there is also an exception for that measure that if you do not have broadband access in your region and you can look this up on a link that we have available on our website that you can actually type in the address of your service location and determine if you qualify for that exception that does show the actual broadband capabilities in the regions.

Sherry Tutor: OK, thank you.

Operator: Your next question comes from the line of Shari Mouradian.

Shari Mouradian: Hi, Shari Mouradian, Lakeshore Eye Care Professionals. I have a question regarding the previous team – practice team physician who is coming to start at our practice. Does he still have to meet for the Medicare to meet the 24,000? And also he is credentialed at the other office, we have to re-credential him, is this a hardship case then?

Elisabeth Myers: So – this is Beth Myers from CMS. I’m not – I’m not quite positive that I understand the part about the 24,000, are we credentialing? But if you have a provider that is moving from one practice to another, if 50 percent of the patient encounters that they had at their previous practice had an EHR at the practice, you do need to incorporate that data. If they were not in an EHR, then you wouldn’t have to bring that data over. But the 50 percent threshold is the data that you need to be using it for your EHR denominator.

And that provider, regardless of where they practice before, could potentially be subjected to a payment adjustment if they see Medicare patients. So the Medicare payment adjustment does not get blocked by moving practices. It is, as we mentioned previously, the same way participation timelines are linked to the individual provider.

In terms of recredentialing them, if they’ve participated in the past, they should have an active registration in the Meaningful Use Registration and Attestation System. You would simply need to have them go in and update their contact information. And they may also have to go into the PECOS system and update any payment information if they have reassigned their payment or assigned proxies for their EHR participation. They would need to go in and do that, but all of that can be done through those systems. There’s not a re-credentialing process.

Diane Maupai: Thank you, Beth.

Operator: Your next question comes from the line of Joyce Bellish.

Joyce Bellish: Hi. Well, Dr. Bannister wanted to know for 2014 to …

Female: What is the new guideline?

Joyce Bellish: Yes. The new guidelines if the EMR is not able to meet MU2, can they redo MU1?

Elisabeth Myers: So, you're talking about the notice of public rulemaking that was released last week? This is Beth Myers from CMS.

Joyce Bellish: Yes Beth.

Elisabeth Myers: We did propose a new regulation. This is not the forum in which we can talk about that regulation because it is proposed only. It has not been finalized. It is currently in public comment period. We do encourage you to take a look at that on the federal register and co – and read it and comment if you have comments on it. Bu, again, it is not a finalized regulation yet so we cannot discuss the proposals in it because they aren't final for the program and will not be until the public comment period closes.

Joyce Bellish: OK.

Diane Maupai: Thank you Beth.

Joyce Bellish: Thank you.

Operator: Your next question comes from the line of Chantal Bryant. Chantelle, your line is open.

Chantal Bryant: Sorry. This is Chantelle from ChiroTouch. I actually had a similar question to the last office regarding the proposed rule, but since you can't discuss that, then you can move on to the next question. Thank you.

Operator: Your next question comes from the line of Kimberly Kirkwood.

Kimberly Kirkwood: Yes, I'd like to find out on the menu measures, what do you – what exactly is the syndromic surveillance data? Exactly what is that?

Elisabeth Myers: So, to give sort of a general overview of it, there's really specific information on it that's available on our website. And I think that's probably the best way to take a look at that. So I'll have to tell you how to get there.

Kimberly Kirkwood: Yes, tell me how to get there.

Elisabeth Myers: Right. So syndromic surveillance registries are some of the registries that various states have – there're some regional ones as well. Where certain disease types that are categorized and sort of required by each independent registry. There are certain ones that take – it is hard to describe, but there are some instances that they take certain types of diseases, like H1N1 was one that Pennsylvania was tracking for quite a while. So they'll require you to report and monitor those particular types of diseases. So that's sort of generally what it is.

But if you look on our website, and that's cms.gov/ehrincentiveprogram.

Kimberly Kirkwood: ehrincentiveprogram?

Elisabeth Myers: Yes, on the left hand side…

Kimberly Kirkwood: OK.

Elisabeth Myers: side, there is a Stage 2 link. And I'm sending you the Stage 2 link because the syndromic surveillance fact sheet is a little bit easier to see in there.

Kimberly Kirkwood: OK.

Diane Maupai: You hit that Stage 2 link and you'll see a list of potential links under where it says "Click here for." And scroll down a little bit and you'll see "Click here for" and a whole set of resources. The one that I want you to look at is the one that says Stage 2 Meaningful Use Specification Sheet, Table of Contents for Eligible Hospitals and Cost, and then one of the options in that is syndromic surveillance. And that will give you quite a lot of information …

Diane Maupai: OK. And I want to tell you that the link to that Meaningful Use Stage 2 webpage is on slide 32. I believe it's – yes, slide 32.

Kimberly Kirkwood: Slide 32.

Diane Maupai Yes.

Kimberly Kirkwood: All right.

Diane Maupai The first one.

Kimberly Kirkwood: Slide 32, OK. Hey, thank you.

Diane Maupai: Sure.

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

Darlene Lackey: Good afternoon. This is Darlene Lackey with Arkansas Health Group and I have a PQRS question. I have 55 providers that are participating in the CPCI program so I'm going to report their PQRS through their CPCI program. But I have about 50 other individual providers and I've just been trying to decide what is the best method to report for them. And I just wanted clarify, if I did it using their Meaningful Use

Clinical Quality Measures for their reporting, is that going to tie up their Meaningful Use instead of payment until it's verified that they're meeting in PQRS measures?

Tim Jackson: Yes, this is Tim Jackson for CCSQ. And the answer to that is yes. The verification for PQRS will precede their credit for MU because it's relying on the PQRS program to confirm that there's Clinical Quality Measures they've satisfied.

Darlene Lackey: OK.

Tim Jackson: Does that answer your question?

Darlene Lackey: It does. It's just a little bit of a struggle to decide a path for them whether I should just go ahead and use, just like a registry and use measure groups.

Tim Jackson: So. There are many registries that are available and we do encourage that, but we have to probably talk more in depth about what your options are – I could refer you to the – well, you probably are already familiar with the Web portal so you can also reach out to the EHR help or the QualityNet helpdesk to get further answers if you want to talk individually about some of those folks and who would be benefitting from a registry or not.

Darlene Lackey: OK thank you, sir.

Operator: And your next question will come from the line of DeeAnne McCallin.

DeeAnne McCallin: Hi, this is DeeAnne McCallin with CalHIPSO in California REC. I wanted to see if anybody on the call could answer why the Medicare providers who were beyond their first year of Meaningful Use are restricted to the calendar quarter in 2014 for their reporting period?

Elisabeth Myers: So, it's because it's in the regulation. That was what was determined in the regulation when we determined to do flexibility in Stage 2. Otherwise, it would have been a full calendar year for providers who were beyond their first year of Meaningful Use. Recognizing that because it was a changeover a year both between Stage 1 and Stage 2 and also between 2011 and 2014 CEHRT, the decision at that time making the regulation was made in order to allow for greater flexibility. I believe that there are systems reasons that they are on the quarter instead of any 3-month period.

Diane Maupai: Thank you Beth.

Operator: And your next question will come from the line of Renea Soloninka.

Renea Soloninka: Yes, my name is Renea Soloninka and I'm with Dr. Kenneth McNamee and the PQRSs, we have been reporting ours via claims. And is it my understanding that it's now mandatory that they be sent in electronically?

Tim Jackson: Yes.

Minet Javellana: This is Minet from CMS. Those are two different sets of measures. So for the electronic Clinical Quality Measures, yes, if you are participating in the PQRS program, you will report them electronically through, you know, the PQRS portal that Brahma had described.

Renea Soloninka: OK. I'm sorry, I didn't understand what he said. I was wondering where I'm supposed to go to send them in electronically.

Diane Maupai: Thank you Minet.

Brahma Sen: Hi, this is Brahma Sen. If I could say that in terms of PQRS portal, you could go to the QualityNet website has the link and there you can – if you have the IACS account, you would be able to log in to PQRS portal to submit your data.

Renea Soloninka: OK. Alright, thank you.

Brahma Sen: Sure.

Diane Maupai: Thank you Brahma.

Operator: Your next question comes from the line of Jennifer Meeks.

Dr. Halnt: Thanks, this is Dr. Halnt. Thank you for hosting this session today. It's very helpful. My question is specific to the secure messaging objective and recent FAQ that CMS put out about a month ago related to the halo effect. And there's been many questions that have been going around here at Spectrum Health as well as across the country in terms of how CMS is defining a group practice in terms of how the halo effect actually affects people's ability to get credit for a secure message if another provider actually does receive the secure message.

And so my question is, is in terms of how the halo effect will apply, is it going to apply to those EPs that are in the same tax ID number? Or will it apply to those EPs that are using the same certified EHR? And so there's some confusion there so any clarification would be really helpful.

Elisabeth Myers: Sure, first – this is Beth Myers from CMS. First off, I'd like to clarify, I know that the halo effect term was out there for a while. We are really trying hard to stop using that because it's being used for a couple of different objectives that actually completely are not the same thing.

Dr. Halnt: I agree.

Elisabeth Myers: The messaging is an example of that. So, for example, the test procedure on a transition of care has a quote "halo effect" or as we're trying to call it but any – just sort of describe it as what it is, that you do that test and then it applies for everyone in the group practice. The secure messaging is not the same. Secure messaging, it would apply within a practice setting or within people who are sharing an EHR if the – if they all saw the patient. So the denominator is actually different. They have to have seen the patient in question during the reporting period.

So it's not a blanket "halo effect" for everyone. So if a patient sees three providers in a group practice and then emails one of them, all three that saw that patient can get credit for that, especially because they're maybe emailing the group practice itself or a practice mailbox because they maybe emailing their primary care provider about something that specialist said. So we understand that. But you do have to have seen the patient during the reporting period in order to even have them in your denominator and count them in your numerator.

So, it's – please try and let – you know, keep away from the halo effect concept because it's not – it's being used universally applicable across multiple objectives that are not actually – that are apples and oranges frankly. So in terms of what we consider a group practice, we haven't specifically defined that. That question hadn't been asked in that particular way previously. For transitions of care, for example, we define – we allow for some flexibility around a group practice so you can do it by individual NPI. But on the safe side, I would say that if you are – have the same tax ID number, for example, it's a – it's a perfectly acceptable way of applying that.

We do, however, require that however you choose to apply that within your practice or practice setting, you must do it universally for all patients.

Dr. Halnt: I'll question. So if you're a provider – you know, if you're a snow bird and a patient goes to Florida and sees a physician who's using the exact certified EHR, let's say Epic for example in Florida. And then they come back to Michigan when the weather is nice …

Elisabeth Myers: No.

Dr. Halnt: … and they're seeing now a different provider but it just so happens that provider is also using the same certified functionality.

Elisabeth Myers: No, that would not count.

Dr. Halnt: Would there be an opportunity?

Elisabeth Myers: No.

Dr. Halnt: Because they've seen that patient within the same – you know, there's been a patient encounter. Then if there's …

Elisabeth Myers: No, that would not count. That would not count.

Dr. Halnt: That would not count. OK, thank you.

Operator: Your next question comes from the line of Tina Sparke.

Tina Sparke: Hello, this is Tina Sparke. My question has to do with core number eight, Meaningful Use. It states in there that you need to show race and ethnicity on the clinical summary. And where I'm having some problems with some of our providers not showing this information. If we exclude that, would that not – would that count against us on Meaningful Use?

Elisabeth Myers: No, it doesn't. If you – you have to include it if it's there. If you have the information, you have to include it. But if you don't, no.

Tina Sparke: OK.

Elisabeth Myers: No …

Tina Sparke: We do have the information data …

Elisabeth Myers: … structured data if available.

Tina Sparke: OK. So if it's available, we have to show it.

Elisabeth Myers: Right. And you have to include it as structured data if it's available.

Tina Sparke: Yes, OK that's what I thought. Thank you.

Elisabeth Myers: Sure.

Operator: Your next question comes from the line of Shelly vantRiet.

Shelly vantRiet: Hello, this is Shelly vantRiet from VCU Health System. My question is our Meaningful Use Stage 2 reporting period ends December 31st of '14 giving us a submission deadline of February. We're a large GPRO and we'll be participating in PQRS via the GPRO Web for 2014, which reports at a later date in March. How do we dually report without incurring a penalty for later reporting for Meaningful Use?

Tim Jackson: That's pretty complex.

Elisabeth Myers: So you're talking about the – the GPRO deadline which is further extended?

Shelly vantRiet: Yes.

Elisabeth Myers: Because the GPRO deadline is later than our deadline

Shelly vantRiet: Yes.

Elisabeth Myers: OK.

Shelly vantRiet: Correct.

Elisabeth Myers: … deadline is later than our deadline, yes. OK. So this is Beth Myers from CMS. So you wouldn't be penalized. It doesn't work that way. …Our systems talk through each other. The reason that there's even a delay is simply because our systems talking to each other in the backend.

Your system, your registration and attestation, you would check a box that says that you're submitting electronically. That would then put your registration and attestation – your attestation for however many providers it is, into our queue of things that are pending verification with PQRS. If it's a hospital, it will be pending verification with IQR. So, it is not considered an incomplete attestation. It is a complete attestation, it just won't stay locked for payment because of its pending verification from PQRS.

And then, passing it to PQRS …

Tim Jackson: Then once you submitted or the – if you're submitting through a portal, that goes through the basically the submission engine that Brahma reviewed previously. Once that's accepted and validated and you get your confirmation message back from that, then that data is going to be sent over into the national repository where it's going to be validated and Meaningful Use credit will be locked for payment at that time. And then 28 days later, you get paid.

Elisabeth Myers: Correct.

Shelly vantRiet: Thank you.

Operator: Your next question comes from the line of Claire DiCarlo.

Claire DiCarlo: Yes. Hi, this is Claire calling from the Diabetes and Endocrinology Center in New York. Actually I've just been listening to most of the questions and I did have a question regarding the new flexibility and extending Stage 2, but I guess we can't comment on that so …

Elisabeth Myers: No, as I mentioned, it is a proposed rule, not a finalized rule, which means this is not an effective regulation. We do encourage you, again, please read it, please comment on it. I will also encourage you to comment early. The sooner we get comments in, the sooner we can start working through them.

Claire DiCarlo: Yes, I've read the whole – I've read the whole proposed rule so it's very interesting. Secondly, so the PQRS for 2014 cannot be reported on claims with the codes?

Tim Jackson: So can you clarify "with the codes," what do the codes mean? I'm sorry.

Claire DiCarlo: With the CPT codes. You can't add those to the office visit for 2014?

Tim Jackson Yes … I think we'd have to refer this …

Claire DiCarlo: You have to do it electronically?

Tim Jackson: I'm not quite sure I'm understanding the full question. We probably have to refer it for further help.

Claire DiCarlo: OK.

Tim Jackson: Yes.

Claire DiCarlo: Thank you.

Tim Jackson: Sorry?

Diane Maupai: Thank you.

Operator: Your next question comes from the line of Dr. Theresa Drew.

Dr. Theresa Drew: I'm sorry, the question already got answered. Thank you.

Operator: Your next question comes from the line of Heidi Harting

Heidi Harting: Yes, thank you. The question also regarding – well, the first question is, if we are granted – if we submit and are granted an exemption – if a provider has granted exemption, how does that display on this physician compare website? Will it just clearly display that they're not participating in Meaningful Use? That they're exempt for this year? How will that display?

Tim Jackson: Physician compare.

Brahma Sen: I'll take it.

Elizabeth Myers: (Inaudible) display.

Tim Jackson: For MU exemption.

Elisabeth Myers: I don’t know.

Tim Jackson inaudible

Elisabeth Myers: I don’t know – so at present, it doesn’t do that. It doesn’t – it doesn’t display that. But we would have to check and see that one. I think that that’s a followup question.

Tim Jackson: Yes.

Heidi Harting: OK.

Diane Maupai: You can email that to …

Female: Yes.

Diane Maupai: If you could – if you look on slide – let’s see.

Minet Javellana: 31.

Diane Maupai: Yes. If you look on slide 31, there’s an email address there for Mathematica. If you can send that particular question there, we can do a little more followup and get back to you. And when we – after this question-and-answer session, I will give you the number for our information center and tell you which followup questions should go there and also to this email address. So thank you, but sorry we can’t answer you right now.

Heidi Harting: Oh, that’s OK, I’d rather have an honest answer. Second – and it kind of dovetails on what somebody else had asked earlier. Our practice has a lot of acquisitions this year and at the end of last year so a provider was – and when we’re getting our 2014 EH – certified EHR in place at the end of July, so a lot of these providers are in their first year as MU. And they’re waiting to get onto the system. Would they – but some of them have not started with us yet, would they apply as an individual already? Is there any suggestion on how to apply for that exemption meaning …

Elisabeth Myers: Yes.

Heidi Harting: … direction on which – direction on which to pick for them?

Elisabeth Myers: Sure. So the hardship exception application is due July 1st. And what I would do is for each of them, apply for a hardship exception for them, even if they haven’t started, they still technically eligible for the program as long as they have an NPI because it links to each individual provider. You can either provide them the information to do it on their own or if they have proxy designations or are going to have proxy designations then it would be acceptable to assist them with the process.

Apply for that hardship exception, that will get them out of the 2015 payment adjustment. And then as soon as the systems are ready for them to be able to go ahead and start their Meaningful Use reporting period, they can do so, which will allow them to get it done in 2014, which is a benefit not only to avoid the 2016 payment adjustment but that gets them on the incentive track, because 2014 is the last year to start for Medicare – for Medicare only – in order to get on the incentive payment track.

Heidi Harting: OK, is there any direction you can offer on which of the exemptions they should request since we can't type it in?

Elisabeth Myers: So in the – on the form for eligible professionals, which you can find on our website, cms.gov/ehrincentiveprograms on the last – on the left-hand side, there's a navigation that says "Payment Adjustments and Hardship Exceptions," there's a form for eligible professionals that has the instructions on it for what version to apply for. If they are new participants in Meaningful Use who don't have access to 2014 CEHRT prior to the date that they would need, which is July 1st in order to start, they can apply for the one that – I believe it's 3.2. – it might be 1 or 3, I can't remember which one, I'm sorry. But a 3.2, that section that talks about certification and vendor issues.

And there's an option there that they can check off that says that they were unable to obtain or fully implement 2014 edition certified software in order to complete an EHR reporting period in time for them to get their early reporting period in for 2015 payment adjustment. And I do want to make it very clear that that application right now is just for those new providers who didn't do Meaningful Use in 2013. But they can go ahead and do that, it's on the form. Submit that form prior to July 1st and then they claim the hardship exception and then go ahead and meet Meaningful Use as soon as they have the system in place and are able to do so.

Heidi Harting: OK, I had understood that to be a vendor issue, not necessarily an implementation – you know, that the vendor has caused the issue per se.

Elisabeth Myers: No, no, if you …

Heidi Harting: That's great, if we …

Elisabeth Myers: Yes, if you look at that form, there are three options under it. And this is actually a question we get a lot so everyone should take a look at it if they need it. On that form, that particular item that talks about 2014 CEHRT has three options. One is that the product is that – that you are unable to obtain a certified product. The second is that you are unable to install a certified product in time, which means that your vendor's product is certified but you couldn't get it – you were late in the queue or you couldn't get in time. And the third is that you were unable to fully implement, which means that you have everything in place that you need to and it's all working right.

So there are three different things that you would check which one would apply to you.

Heidi Harting: OK great, thank you.

Elisabeth Myers: Sure.

Operator: Your next question comes from the line of Emma Mortimer.

Emma Mortimer: Yes hello. I think most of my questions have already been answered. I would like to make a comment about the PQRS question that keeps coming up though. And I don't know if I can reiterate the question in a way that most people understand. Here and we were discussing the registration – or sorry – the submission of the CQMs via the portal, I believe a lot of the discussion, you know, people throw around the terminology CQM and PQRS and it just causes confusion because a lot of the measures are very similar. Is it my understanding that what you guys have been discussing here today via using the portal – the PQRS portal for electronic submission – is really more – if someone wants to align their CQM or their Clinical Quality Measures submission, which is for Meaningful Use, along with the PQRS program to merge so that they only have to do one submission and that's by submitting via the portal. Would that be an accurate statement?

Tim Jackson: This is Tim and the answer to that is yes, you are correct.

Emma Mortimer: OK. So then when people keep saying – so that means I cannot submit my PQRS via claims. Just to clarify, the PQRS discussion in general, that's a separate program altogether and can still be submitted via claims or via any other method as mentioned by the – you know, I guess you can go to QualityNet for more information on that, right?

Tim Jackson: So that is correct. But the PQRS claims is not suitable for MU credit.

Emma Mortimer: For not – not from aligning with the Meaningful Use?

Tim Jackson: That was not one that was covered. You're not going to find that on the – either on the PQRS or on the Meaningful Use sites or in the Registration and Attestation System. None of those – that you won't find that in –will support that identifies it as claims.

Emma Mortimer: Right, I believe it....

Minet Javellana: So this …

Emma Mortimer: It's, go ahead.

Minet Javellana: So this is Minet. So maybe – I guess, hopefully a helpful way for you to think about it. So PQRS is made up of a couple hundred measures currently. And they do, you know, cover all forms of measures so claims and like GPRO. So the 64 electronic Clinical Quality Measures that are under the Meaningful Use program are a subset of PQRS. So then you have the option of reporting just for Meaningful Use and, again, just electronic Clinical Quality Measures.

So I think maybe in our presentation if we had put a little "e" in front of the CQMs, then, you know, that would signal to you better that it's strictly electronic Clinical Quality Measures that we're referring to.

So hopefully that helped.

Operator: Your next question…

Emma Mortimer: Thanks.

Operator: Your next question comes from the line of Dr. Gita Patel.

Dr. Gita Patel: Hi, my name is Gita Patel, I am a solo practitioner. And my question is in 2011, I did 3 months of Meaningful 1 attestation. And 2012, somehow I had a problem. Some reason I was not able to do it. Then the whole year I did for 2013.

Elisabeth Myers: I'm sorry to interrupt you, could you please repeat your question a little bit louder? We're having difficulty hearing you.

Dr. Gita Patel: OK, so I started the Meaningful Stage 1 in 2011.

Elisabeth Myers: OK.

Dr. Gita Patel: I did it successfully for 3 months and I got a payment, the incentive payment for 2011; 2012, I was not able to do the attestation. And 2013, I did Stage 1 a whole year. What happened is the payment for 2013 did not come as I expected, $12,000. It came $8,000. So my payment was reduced from 12,000 to 8,000. And it was still – there was no Stage 2 available in 2013. So that was one thing.
And my Medicare payment was adjusted in 2013, I assume because I did not do attestation in 2012. And from all these things, I heard that the adjustment will not start until 2015. Can you explain that?

Elisabeth Myers: Sure, I can explain both of those. So first off, because you skipped a year, you forced it at that amount. So the same way that we said earlier that if you – once you start, you have started in Medicare. So your first year, you get a certain amount and that is Stage 1 year 1 and you get a certain amount. Stage 1 year 2, you get a certain amount. Stage 1 year 3, if you are someone like yourself who started in 2011, 2013 was your actual third year of Stage 1, you get another certain amount.

So each year, that amount that you get decreases and if you skip a year, you don't get the same amount, you get the amount that you would have gotten if you hadn't skipped a year. So when you skipped that second year, you skipped the $12,000 payment and you ended up with the $8,000 payment, which would have been your payment either way whether you skipped the year before or not, that would have been your third year payment.

So you'll actually begin 2014 with Stage 2. So you've done your 3 years of Meaningful Use Stage 1. And the reason that that payment that you got in 2013 was less than what you expected is because the 12,000 would have been if you had done it in 2012 during your second year. Because you skipped that year, you go straight on to your third year, no matter what. And as for your actual Medicare payment, there has not been a payment adjustment yet. The payment adjustment doesn't start until 2015.

If you saw a reduction in your Medicare payments, it was likely due to sequestration. Sequestration is a – again, it's Congress. They – part of the budget balancing measures that were put into place a little over a year ago did include a 2 percent reduction across the board in Medicare payments to both your claims payments, the EHR incentive payment, anything related to a Medicare payment did experience a 2 percent reduction and that is not related to Meaningful Use. That's not related to the program we're talking about here today. That's just sequestration, which is a budget balancing measure by Congress.

Dr. Gita Patel: Thank you, but my question is, if I skipped 2012, suppose if I had done first – first Stage 1 for 2011 and if I had done 2012, I would not have been able to do anything in 2013 because there was no Stage 2.

Elisabeth Myers: No, you still could have …

Dr. Gita Patel: …would have missed – I would have missed 1 year anyway.

Elisabeth Myers: No, you would have been in just a third year of Stage 1. Early adopters did Stage 1 for 3 years. No one does Stage 1 or Stage 2 for less than 2 years, but you may end up doing 3 years, depending on how early you started.

Dr. Gita Patel: Thank you.

Operator: Your next question comes from the line of William Fester.

William Fester: Hey, thanks for taking the call. So to clarify, we've been around this question. If you are in year number 2 of Meaningful Use 1 in 2014, you only report one-quarter of data, right? You don't have to do the full year.

Elisabeth Myers: In 2014, no one has to do a full year. So in 2014, you are only reporting a quarter even if you are – if you're anywhere beyond your first year. So Stage 1 year 2, you are only reporting a quarter or Stage 2 year 1, you are only reporting a quarter. Only brand new providers are doing any – are doing 90 days unless it's Medicaid.

Tom Romano: Yes, and this is Tom Romano, just to – just to emphasize that. For the Medicaid EHR Incentive Program, it's 90 days for 2014. Any 90 days as opposed to the Medicare program, which has the fiscal quarter setup.

Elisabeth Myers: And then in 2015, for Medicare, it goes back to a full year for anyone who's not a first time participant.

William Fester: OK. It goes back to a full year in 2015?

Elisabeth Myers: Correct.

Tom Romano: Slide 12 if you still have it.…

William Fester: OK, and can you – can you file for a hardship for 2014 yet? I keep hearing July 1st to prevent the 2015 adjustment. But for folks that, you know, have access to – I mean, my vendor, Greenway, has a certified product but like someone said, it sounded like option two or three will be me, you know, there's such a long line to get it that by the time you get it, implement it, and really know how to use it, these quarters are going to be past us.

So I feel like even though my vendor is advanced and has the ability to give me the right product, you know, I'm not going to be able to – without just bringing us down to our knees, you know, implement the product in time, you know, to get it submitted so. But I guess I have to wait until after July 1st so that it can get it to my year to file the hardship.

Elisabeth Myers: That's correct. So after July 1st of this year, there will be a new form and that new form will have the 2016 date on it. And that form will be out there for anyone who wants to apply. And that form will be due on July 1st of 2015. So you'll have a year once the new form is up to apply for that hardship exception if you need it.

William Fester: OK. Alright, thank you.

Diane Maupai: Thank you Beth.
William Fester: Bye.

Diane Maupai: This is Diane. We have time for one more call. And then I'm going to talk about some additional resources and people you can contact if you have other questions. Thank you, Victoria, one more call – one more question.

Operator: OK. Your final question comes from the line of Parkview Medical Center.

Juli Krupka: Hi, this is Julie from Parkview Medical Center. We're in a relatively small town of 350-some doctors …

Diane Maupai: I'm afraid we lost you. I don't know if you can speak up.

Juli Krupka: Can you hear me now? Can you hear me now?

Diane Maupai: I'm afraid – I guess maybe we can move to the next question, we can't hear a thing. Sorry about that.

Juli Krupka: Hello. Hello.

Diane Maupai: Julie, can you yell even maybe?

Juli Krupka: Can you hear me now?

Diane Maupai: No, We can't …

Elisabeth Myers: I can hear that someone is saying something but that's it.

Operator: Your next question comes from Jackie Crighton.

Jackie Crighton: Hello, this is Jackie Crighton. Can you hear me?

Diane Maupai: Yes.

Jackie Crighton: OK, sorry. I feel bad for the previous group.

Diane Maupai: Actually, it's just in our room. You're coming in and out. I don't know what's – so speak loudly and we'll do our best.

Jackie Crighton: OK, I have a question on the eligible professionals. I'm a small GYN practice and I do have a nurse practitioner in our office. I had not signed them up for Meaningful Use. And I'm realizing maybe I should be doing that. We do a lot of incent – you know, she works under the supervision of the main doctor most of the time, just occasionally when people are out for vacation or holidays. And I'm just wondering I should be signing her up as an individual practitioner as well for the practice?

Elisabeth Myers: So, for Meaningful Use, a nurse practitioner is not eligible for the Medicare program. And …

Jackie Crighton: OK.

Elisabeth Myers: … therefore, is not – does not have a payment adjustment applicable to them. If you're not eligible for the program, you cannot get a payment adjustment either. But I'll pass it off to Medicaid.

Tom Romano: Hi, this is Tom Romano from CMS. So, just to – and just a quick note sort of on the payment adjustment, kind of related to nurse practitioners, just to emphasize, if you're an eligible provider for both Medicare and Medicaid, even if you're participating in the Medicaid program, you can still be – you can still be subject to the payment adjustment potentially. But if you're not eligible for the Medicare program and you're only eligible for the Medicaid program, then you're not subject to the payment adjustment but you do have the opportunity to participate and receive the incentive payment. And that situation with the nurse practitioner, as a – as a – as a provider type, nurse practitioners are eligible for the Medicaid EHR Incentive Program.

So, it will be in a similar registration to begin with as with any of them, so you'd register with the CMS system. And then you'd also register with the state system and attest to the state for nurse practitioners. And so you'd work with the – primarily with the state program for attestations and for the guidance.

Diane Maupai: Alright. Well, thank you Tom.

Jackie Crighton: OK, thank you very much.

Additional Information

Diane Maupai: And that's going to be it for today. I'm sorry we're having some listening issues in—just in our room evidently—so I'm glad you all were able to hear. Hopefully we've been able to address your questions – most of your questions related to Stage 2. In a moment, I'll be telling about some additional resources that are available. But if you can't find what you need there on – the first place you can go if you have questions related to program requirements for the EHR Incentive Program, they can be directed to the EHR Information Center. The number there is 1-888-734-6433. That's 1-888-734-6433. That's a toll free number. For the hearing impaired, it's 1-888-734-6563.

Otherwise, you can submit questions related to Clinical Quality Measures to the email address you see on slide 31 which is e-measures@mathematica.mpr.com. This mailbox will be available to take followup questions for 2 weeks following this presentation, which is through June 12. Please don't submit questions after that time because we can't guarantee that the mailbox will be monitored.

On slide 32, we provide two links to additional resources. The first is to a page we've referenced several times during this call today. It's a link that CMS EHR Incentive Programs Stage 2 webpage. We highly encourage you to look to the resources that are linked on this page for more information about Stage 2 implementation and in particular the Stage 2 guide for eligible professionals, which provides a comprehensive overview of Stage 2.

We've also provided a link that will direct you to CMS's frequently asked questions page. On that page, you can either browse questions and responses specific to the EHR Incentive Program or you can search for a specific topic. It's a great resource that contains a lot of practical information and responses to the types of questions we have addressed during the call today.

On slide 33, you'll see a link to provide feedback on today's presentation. As a reminder, evaluations are anonymous, confidential, and voluntary. We hope you'll take a few moments to evaluate your MLN Connects Call experience.

An audio recording and written transcript of this call will be posted to the MLN Connects Call website on the page where you found the presentation for today's call. An announcement will be placed in the MLN Connects Provide eNews when these are available.

My name is Diane Maupai. I'd like to thank our presenters. And also thank you for participating in today's MLN Connects call. Have a great day everyone.

Operator: This concludes today's call.

-END-