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National Provider Call - Transcript

Centers for Medicare & Medicaid Services
Payment Adjustments and Hardship Exceptions for the Medicare EHR Incentive Program
MLN Connects National Provider Call
Moderator: Diane Maupai
August 15, 2013
1:30 p.m. ET

Contents

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, Brooke. Hi, everyone. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore, and I'm happy to serve as your moderator today. I'd like to welcome you to this MLN Connects National Provider Call on payment adjustments and hardship exceptions under the Medicare EHR Incentive Program. MLN Connects Calls are part of the Medicare Learning Network.

Beginning in 2015, Medicare-eligible professionals, eligible hospitals, and critical access hospitals that do not successfully demonstrate Meaningful Use will be subject to a payment adjustment. Today's call will cover who will be affected by payment adjustments, how the payments adjustments will be applied, and hardship exceptions to avoid the adjustments. A question-and-answer session will follow the presentation.

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

You should have received a link to the slide presentation for today's call in previous registration emails. If you have not already done so, please download the presentation from the—from the following URL: www.cms.gov/npc. Again, that's www.cms.gov/npc. At the left side of the web page, select "National Provider Calls and Events," then select the August 15th call from the list.

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

At this time, I'd like to introduce our speaker. It's Travis Broome. He is the team lead for Policy and Oversight in the HIT Group in the Office of E-Health Standards and Services. So I'll turn it over to you, Travis.

Presentation

Travis Broome: Thanks, Diane. So, we're going to talk about payment adjustments and hardship exemptions today. I'm sure not everyone's favorite topic, but a very important topic as we continue to move forward towards the payment adjustments in 2015.

But probably the most important thing I can tell you on this call, and for you to remember on this call, is everything you need to do before—to avoid a 2015 payment adjustment has to happen before 2015 starts. So everything we're going to be talking about are things

you can either do today to avoid the payment adjustment or things you'll be able to do early next year to avoid the payment adjustment.

Payment Adjustment Applicability

All right. Go all the way to slide 4. I playfully titled this slide "Do I Care?" So if a few of you disconnect after this, I will understand. Only those who are eligible for the Medicare EHR Incentive Program are potentially subject to the Medicare payment adjustment. There is no payment adjustment for Medicaid. So you have to be eligible for Medicare in order to be potentially subject to the payment adjustment.

So, as you can see on slide 4, for our Medicare-only—you know, the doctors of optometry, doctors of podiatry, and chiropractors—and then also those who are dually eligible for both programs—doctors of medicine, doctors of osteopathy, and doctors of dental medicine or surgery, and in some States, also, doctors of optometry are also eligible for both. Those eligible professionals who are only eligible for Medicaid—nurse practitioners, certified nurse midwives, physician's assistants—do not have to worry about the Medicare payment adjustment even if they do independently bill Medicare.

And if you're a professional type—that is, you don't see yourself on this list at all, like a physical therapist—then you just don't have to worry about it at all. You really don't care and you'd probably be in the disconnect group at this point. If you're not eligible for the Medicare incentives, you're not—don't have to worry about the Medicare payment adjustments.

Slide 5 does the same thing for hospitals. Hospitals, you have—you're looking at our sub—so we'll call our subsection (d) hospitals. That's our—mainly our acute care hospitals that are subject to the IPPS rule and also our Maryland hospitals that are acute care but not subject to the Inpatient Prospective Payment System, and our CAHs. Children's hospitals, cancer hospitals—any hospital that is not a critical access hospital, does not use the Inpatient Prospective Payment System, is not located in the 50 U.S. States or the District of Columbia, and is not in Maryland and exempt from the Inpatient Prospective Payment System, you don't have to worry about the payment adjustments. You're not eligible for the Medicare incentives. So therefore, you're not—don't have to worry about the Medicare payment adjustments.

All right. Another group of folks who aren't eligible for the Medicare payment—incentives, so therefore are not subject to the Medicare payment adjustments, are our hospital-based EPs. So, go back to our eligible professionals—remember this is everyone called doctors of something—if you are hospital based, you cannot receive the incentive payment. So, that holds that if you are hospital based, you are not subject to the payment adjustment.

So for 2015, if you are determined to be hospital based in *either*—either of the 2 years prior to the payment adjustment year, then you are not subject to the payment adjustments for that year. So how would this play out in 2015? If you are hospital based for 2013 or you're hospital based for 2014—either/or, or both, if you're both—you are

not subject to the 2015 payment adjustment year. So, you just keep fast-forwarding that for us. So for 2016, it will be ’14 and ’15. For 2017, it will be ’15 and ’16, et cetera, et cetera, et cetera, ongoing.

How do you find out if you’re hospital based? Register for the program. When you come in and register, we will tell you if you’re hospital based. So you can find out if you’re hospital based for 2013 right now by registering. And if you are hospital based for 2013, you are not subject to the 2015 payment adjustment.

If you are not hospital based for 2013 but you’re close—so you think you might be in 2014, come January 1st, 2014, come in to the registration system, find out if you’re hospital based. And if you are, you are not subject to the 2015 payment adjustment.

Payment Adjustment Overview

OK. Now that we’ve narrowed down the group of folks who are potentially subject to the payment adjustments, we’re going to talk a little bit about what they are. So, for those folks who are left who do care about the payment adjustment, this is what it is.

So, it was created by law, obviously, in the HITECH Act. It stipulates that those folks who are eligible for those incentives would also be subject to a payment adjustment if they are not a meaningful EHR user. You become a meaningful EHR user whenever you successfully attest to Meaningful Use. Registration doesn’t do anything for you. Adopt, implement, and upgrade does—is not Meaningful Use. That doesn’t do anything for you, either.

You become a meaningful EHR user and therefore not subject to the payment adjustment once you successfully attest to Meaningful Use either in Medicare, or if you’re dually eligible for both programs, in Medicaid. So you can come through Medicaid and become a meaningful EHR user. But you have to do it by demonstrating and successfully attesting to Meaningful Use, not through adopt, implement, and upgrade.

So, slide 8 is really what we’ll call the BRAC tax slide for 2016. So, if you—if you’ve listened to this presentation so far, and you determine that “Yes, I am potentially subject to the payment adjustments,” this is what you need to do to avoid in 2015. These are your deadlines.

So either demonstrate Meaningful Use to CMS or the State through the Medicaid program. If you were a meaningful user in 2011 or 2012, then you have to end your EHR reporting period by December 31st, 2013, because you have that full year for 2013, and attest by February 28, 2013—or ’14. Sorry, a mistake on that slide. So, you’d end your EHR reporting period by December 31st, 2013. And then you have 2 months after that, so through the end of February 2014, to attest.

If you have never been a meaningful EHR user before in 2011 or 2012, then you can attest to any 90-day period starting now, starting anytime in 2013, all the way through ending your period on September 30th, 2014. And then—but, if you wait that long, if you

wait to that last minute, you have to turn around and attest on the next day, October 1st, 2014.

So, the advice: Never, never, never attest or wait that long because then you don't want something funky to happen on October 1st and then you miss the deadline. So always give yourself at least a couple of months, end your reporting period, you know, in June, late May, so you have plenty of time to work out the administrative side of the program.

Hospitals work on the fiscal year, not the calendar year. So you can just take all those dates, subtract 3 months, and you find the hospital date. If you are going with a hardship exemption (we'll talk more about those in detail later) as opposed to becoming a meaningful EHR user, those applications for those who have to apply to get it—not everyone that gets one has to apply (like I said, we'll talk more details about that later)—must apply, if you're an eligible professional, by July 1st, 2014. If you're a hospital, subtract 3 months—October—or April 1st, 2014.

So let me say a quick word about why all this stuff's happening in '13 and '14. We need to know ahead of time whether or not someone is subject to the payment adjustment or not. The law requires that all claims submitted for services in 2015 are subject to—potentially subject to the payment adjustment from an eligible professional.

If we do not know before the start of 2015 whether you are subject or not, we would have to guess. Guessing is—and it would literally be that. Simply a guess. It might be a slightly educated guess, but it would be a guess nonetheless. And if it turns out that guess is wrong, we would have to reprocess all of those claims for eligible professionals, for the hospitals, from the time of our wrong guess, so January 1st, 2015 (or October 1st, 2014, if you're a hospital) to whenever we figured out that the guess was wrong. Reprocessing claims is a very, very expensive proposition for both providers and us. And every scenario we came up with, it would cost significantly more to reprocess claims than the payment adjustments itself.

If you look on slide 9, we actually talk about how much the payment adjustment is. So for eligible professionals, how much money are we talking about here? The law put in a little provision. So this is why you see the little tables of whether less or more than 75 percent of eligible professionals are meaningful users by 2018, the penalty—or the payment adjustments go up.

If less than 75 percent—as you can see there 99, 98, 97, 96, 95, with a cap at 95. If come 2018 more than 75 percent of EPs are meaningful users, then the highest the payment adjustment gets is 97-percent reimbursement rate, or, to put it another way, the payment adjustment is 3-percent cap.

We're well on our way to that 75 percent number now. We're coming in on 50 percent of people—of EPs participating in either AAU or meaningful use already. And here we are in the early second half of 2013. So we have 4.5 years to go to make up the 25 percent.

So, most likely, we're going to be looking at the bottom table. But obviously, we'll know that for sure once 2018 rolls around.

So, I kind of gave you the dates earlier on this slide. This slide here on 10 kind of shows you how those dates work rolling forward into history. So, basically, you can think of it as once I've attested to Meaningful Use once in either program, Medicare or Medicaid, after that, my EHR reporting period for a payment adjustment year is going to be 2 years ahead of time.

So if I attested for the first time in 2012 in, let's say, Medicaid, then I have to attest in 2013 again to avoid the 2015 payment adjustment—'14–'16, '15–'17, '16–'18, so forth, so on.

On slide 11, it talks about those—it just shows you the different reporting periods for folks who attest in 2013 for the first time.

Slide 12 really gets to our special case, if you will. So, when I attest to Meaningful Use for the first time in either program, Medicare or Medicaid, I get a little more time to do so to avoid that payment adjustment year.

So, to avoid the 2015 payment adjustment, and let's say it's now August 15th, 2014, instead of 2013. So my chance to do it in '13 has passed, but I can still avoid the 2015 payment adjustment. You have to do any 90 days in 2014 prior to October 1st, like I talked about earlier, or, for a hospital, July 1st. That one year, when I do it in that one—that will get me credit for the next 2 years.

So if I were to attest, let's say, January, February, March of 2014, and I come in and I attest in April and everything works out, I'm now a meaningful EHR user. That will avoid the 2015 payment adjustment. That will avoid the 2016 payment adjustment. I still must attest in 2015 because once I've done that first year, I'm going to get on that same 2-year cycle that everybody else is on. So 2015–'17, '16–'18, '17–'19, '19–'20.

This is true not only for 2014 but each year going forward. So you can move all these dates up by the same number of years and it would still work the same way. So, the slide could start with 2019 and 2020 and move forward.

OK. How much is it for hospitals? It's not quite as cut and dry for hospitals. Sorry. So, slide 13. I'm not controlling your slides, so I don't know why I apologize for dancing them on you. But on slide 13 is what I'm looking at now—they have the IPPS, so the Inpatient Patient—Inpatient Prospective Payment System has an annual update. That annual update is different each year. This year, it's pretty low—less than 1 percent this year. Other years, it's been as high as 3 or 4 percent. Whatever that update is for a given year, if you're subject to the payment adjustment, you would only get—in 2015, you would only get 75 percent of that payment adjustment.

In 2016, if you are subject to the payment adjustment, you'd only get 50 percent of that update. In 2017, if you were 75 percent of—of that—if you were subject to the payment adjustment in 2017, you would only get 25 percent of the update, and so on and so forth, capped out at 75 percent, obviously.

There is an example of how that math would work on the bottom. So, if it was 2 percent for 2015 times 25 percent, it means you get a half a percentage of a payment adjustment. So, instead of getting a 2-percent increase, you would only get a 1.5-percent increase.

This goes through the reporting periods for subsection (d) or Inpatient Prospective Payment hospitals, those acute care hospitals. Same thing we saw in EPs: rolling 2-year prospective determination. And there's actually a typo in these slides—this must be from an old set—but the—you know on slide 14, it says 2019–2020. It should be 2018–2020.

Same situation for a hospital on slide 15. When's kind of the last day you can do to avoid it? Again, you can avoid it with a 90-day EHR reporting period in 2014. When you do that, it'll cover '15 and '16. And then you'll move forward on a 2-year rolling basis. Again, with that last table in slide 15, it's supposed to be 2018.

And this is, again, true whether you do it in 2014 for the first year or 2019 for the first year. If 2019's my first year of Meaningful Use, then I will—when I do it in 2019, by July 1st, 2019, I will avoid the 2020 payment adjustment, I will avoid the 2021 payment adjustment, and then 2022 will take care of my 2024 payment adjustment.

Critical access hospitals are different. They are reimbursed on what is known as a reasonable cost reimbursement payment. So rather than paying you a set price for a diagnostic-related group or a set price for a certain procedure in the office visit, critical access hospitals are reimbursed, basically, at cost. And not just at cost, but at 101 percent of cost.

The payment adjustment for critical access hospitals is, over time, as you can see on slide 16, they would lose that 1 percent.

Diane Maupai: Hey, Travis?

Travis Broome: Yes.

Diane Maupai: This is Diane. Can I interrupt you for a second?

Travis Broome: Sure.

Diane Maupai: We're picking up people talking in the background. It's kind of hard to follow you. I don't know if you have people in—you know, near you that maybe you could ask to be quiet or something?

Travis Broome: Sure. Let me just switch to my handset and see if it helps. Hopefully that's better.

Diane Maupai: That's better for me. Thank you.

Travis Broome: Yes, sorry. Yes, the Government certainly doesn't spring for offices for us all, so I have cube mates who are—all right.

On slide 17 you'll notice this is the critical access hospital reporting period and, as you would notice, that there is the difference here, a big difference. The reporting period's in the same year as the payment adjustment year. The reason for this is that cost reimbursement method, as opposed to a prospective payment and fee schedule.

So every year when a critical access hospital goes through—they get paid during the year based on estimations of what their costs will be, and at the end of the year, those costs are reconciled with what the actual costs were. That reconciliation makes those payments vary by more than the 1-percent maximum payment adjustment they would be subject to.

So we're able to roll the payment adjustment up into that reconciliation process without affecting materially the variation of payments they get, unlike, you know, when we were talking about IPPS and EPs where you would actually have to reprocess the claims. So, for that reason, we can do the reporting period during the year, which makes this slide very simple—2015–2015, '16–'16, '17–'17, et cetera.

All right. So that is what the payment adjustments are, how much they are, when you need to become a meaningful EHR user to avoid any given payment adjustment.

Hardship Exceptions Overview

You heard me mention on my dates slide, though, that there is provisions for what we call hardship exceptions. And there—we're going to start talking about those on slide 18. These are for eligible professionals. There are ***five*** categories.

Clarification: There are five categories.

One is for infrastructure. EPs must demonstrate that they are in an area ***without*** sufficient Internet access or face insurmountable barriers to obtaining infrastructure needed to be a meaningful user. We have our new EPs. So, with a prospective determination, obviously we need to give them enough time—namely, the time of the prospection, 2 years—to become a meaningful EHR user before the payment adjustment is applied.

Clarification: EPs must demonstrate that they are in an area without sufficient Internet access or face insurmountable barriers to obtaining infrastructure needed to be a meaningful user.

Unforeseen circumstances. These are the classic natural disasters and then the more health information technology–specific occurrences, like my EHR developer went out of business.

And then the last two are very specific to eligible professionals. You won't see them when we go to the hospital slide. One is for EPs who specialize in such a way that they lack face-to-face or telemedicine interaction with patients *and* they lack a followup need with patients.

And then other EPs who practice at multiple locations or one location—outpatient location where they can't control whether they have certified EHR technology available or not. There is a provision in Meaningful Use for those EPs, that if that percentage of their encounters is less than 50 percent of their encounters they don't have certified EHR technology for, they can just exclude those encounters from Meaningful Use.

If it's more than 50 percent of their encounters, then they are not eligible for Meaningful Use. Which is fine on the incentive side—or it works on the incentive side because it's an incentive program. On the payment adjustment side, we certainly don't want to penalize these providers if they don't have control over whether certified EHR technology is available or not for not meeting Meaningful Use. So there is a hardship exception for these. And I'll go over each one of these in more detail on the next slides.

Hospital. They obviously—you don't have the last two, like I mentioned, but then you have the first two. So—infrastructure, new hospitals, unforeseen circumstances.

So what do we mean by Internet infrastructure? So, the infrastructure—or the Internet connectivity that you need for Meaningful Use isn't the same that you need to just send an email. And we're well aware of that and we're moving on that. But obviously the first criteria is if you cannot even get wired Internet to your location at all, at any cost, obviously that's a hardship exemption.

That's not going to be true for most people. Almost everybody can get it. But there still might be two problems: One, it might be cost prohibitive due to the need to build out physical infrastructure to your facility, or what you can get might be insufficient speed for Meaningful Use. So it might be good enough to send email but it might not—might not be good enough to run—send up all the patient information you need to put online for your patients or to send summary of care records using direct protocols.

So, how do I apply—this is an application one. So, you've got to tell us that this applies to you. And you've got to demonstrate in your application to us that one of those things occurs—either you have no Internet, or the Internet that is available is cost prohibitive or insufficient for any 90-day periods in the 18 months prior to the application deadline of July 1st the year before the payment adjustment year.

So if it was July 1, 2014, is when your application is due. So you have to demonstrate that you lacked that Internet—either completely, or due to cost, or just because it wasn't available at any cost, or due to its insufficient nature—for a 90-day period between January 1st, 2013, and July 1st, 2014, to get the hardship exemption for 2015.

Now, things that might be considered proof for these—you know, quotes or correspondence from at least two different Internet service providers. You know, for insufficient speed, you know, the above—you know, kind of like the quotes for upgrades being too cost prohibitive, combined with, maybe, support from your certified EHR technology developer that what you got is insufficient to run your EHR. You know—and these are just examples of ways that you might go about proving this. I mean, obviously each situation is going to be different, and we would look at each situation individually. But just to kind of get your minds rolling if you might be in this situation on proving this particular one.

So for new EPs, no application needed. We will determine using Medicare claims data and enrollment data. And again, this is 2 years after an EP starts practicing they get this exception. So, for 2015, we're going to be looking at claims data and enrollment data before 2013.

Right. So, if you're submitting Medicare claims as an individual provider in the middle of 2012, you're not going to be getting this exemption. If you submitted your first Medicare claim ever and enrolled with Medicare for the first time ever in the middle of 2013, you will be getting this exception. But again, there is no need to apply because we know this easily enough from our own data.

Same thing with hospitals. Hospitals have to enroll with Medicare. We know when you enrolled. We know when your cost—we get your cost reports. We know when you've had a full cost reporting period. So, I mean, no need to apply as a new hospital. We will know who you are and which ones aren't.

Unforeseen circumstances. So obviously, this is one of those that is, by its very nature, case dependent. So you will need to apply for this one. Some examples that were listed in the rule—you know, you closed, the local hospital closed and you are an EP and you're relocating, your EHR loses certification, there was a natural disaster in your area, you went through bankruptcy or other debt restructuring. You know—so any circumstance that is beyond your control and detrimentally impacts your ability to meet Meaningful Use.

So when you do your application, got to tell us why whatever happened means you can't do Meaningful Use. Just that something bad happened doesn't necessarily mean you can't do Meaningful Use. So don't just outline your situation to us and then expect us to determine whether it would affect Meaningful Use or not. You know, when you do your application, be sure to directly make that link.

Some of them are extremely obvious. Obviously, if your EHR loses certification in 2014, you know, it doesn't get recertified to 2014 and you found that out on December 2013, you know, you're not going to be able to do Meaningful Use, probably, in 2014 because it would involve getting a new vendor. But even in that case, always make that link. So that's our main advice here on that one.

Scope of practice. Both things—you know, I kind of highlighted it before, but both things—a lack of face-to-face or telemedicine interactions with patients *and* a lack of followup need with patients. So, we're basically just going to ask you to attest, you know, make an attestation statement—we'll have forms and stuff up for you to do that early next year—that you or your specialty is in these situations.

We will be doing some checking on our end and just to kind of give you some guidance on your end about whether or not potential disqualifiers—so it's not to say these are automatic things that are disqualifying you, but certainly things that you would want to be aware of when considering whether you meet these and possibly address in supplemental information to your attestation. So, if you're billing E&M codes to us, if you're developing care plans that involve followup with you as the EP, you know, obviously, these things would be red flags towards meeting this particular measure.

There are three specialties for—we set in the regulation that do meet that criteria. They're anesthesiology, pathology, and radiology. The rule specifically said that you don't need to apply for these, that we would use the Medicare enrollments specialty codes as of July 1st the prior year. So for 2015 it'd be July 1st, 2014.

So, to get this particular exception, if you are in anesthesiology, pathology, and radiology, the only thing you need to do is to ensure that in your Medicare enrollment, one of the specialties below—diagnostic radiology, nuclear medicine, interventional radiology, anesthesiology, or pathology—is listed as one of your primary specialties in your Medicare enrollment prior to July 1st, 2014. If that is not the case, you can—in your enrollment thing, you can always go back to slide 24 and submit an application. However, it's much, much simpler just to go through and ensure your enrollment is correct about your primary specialty than it would be to submit an application and potentially engage in the back and forth that that would entail.

The final hardship exemption was lack of control over the availability of certified EHR technology. There are really two criteria here. One, less than 50 percent of your outpatients encounters are at locations equipped with certified EHR technology. The—so that means that you—less than 50 percent, because if it's more than 50 percent, you can meet Meaningful Use and just ignore the 49.99 percent that is at locations that are not equipped with certified EHR technology.

The other thing is that you have little or no control over whether those locations are equipped with certified EHR technologies. Examples for proof, you know, for the 50-percent eligibility piece, you know, we accept as attestation for that for the Meaningful Use side—the incentive side. So, we will accept attestation on the hardship on the payment adjustment side, as well. This would be a very difficult thing for us to prove, you know, short of having you basically submit all of your billing data, which is not what we're after.

But the "have little or no control," that would be a little more than an attestation. We would ask that you identify those locations that are not equipped with certified EHR

technology to us and then provide, you know, either the actual agreement or summaries of agreements or information that demonstrates that you truly do have no—little or no control over whether these locations are equipped. So, you know, you don't have an ownership stake, for instance, or you don't play a management role at the certified EHR technology.

You know, there are—you know, red flags, gut-type things might be, you know, if you reassign claims to that facility, then, you know, really the facility's the one getting hit with the payment adjustment, which is probably right if they control over whether the certified EHR technology is available or not.

Resources

Yes. So, for the ones that were applications, this is kind of—slide 27 talks through how to apply for these hardship exemptions.

And with that I think I will turn it over to Diane to make a few announcements and—on the remaining slides before we go to Q&A.

Keypad Polling

Diane Maupai: OK. Thank you, Travis.

I'm going to ask you to put yourself on mute there. We can still—it's much better, but we can still hear a couple people behind you.

Travis Broome: Yes.

Diane Maupai: Thank you very much for that good presentation.

At this time, we're going to pause for a few minutes to complete keypad polling so 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.

Brooke, we're ready to start polling.

Operator: OK. 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.

Special Announcement

Diane Maupai: Before we start the question-and-answer session, we'd like to make a special announcement.

CMS will soon provide a new opportunity for Medicare-enrolled providers and suppliers to give us feedback about your experience with your Medicare Administrative Contractor, or MAC. That's the contractor that processes your Medicare claims. Your feedback will help CMS monitor MAC performance trends, improve oversight, and increase efficiency of the Medicare program.

Each year, CMS will send a short online survey to randomly selected providers who have registered to participate. If you would like to register for an opportunity to evaluate your MAC or for more information, please visit the website listed on slide 28 of this deck. Thank you.

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.

Question-and-Answer Session

To ask a question, press star followed by the number 1 on your touchtone telephone. 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: Again, before asking your question, please state your name and the name of your organization. And 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'd like to ask a followup, just hit star 1 to get back into the queue, and we'll address your additional questions as time permits.

So, Brooke, we're ready when you're ready to take the first question.

Operator: OK. Your first question comes from Denise Sharma.

Denise Sharma: Hello. This is Denise Sharma. I just had a quick question. Travis, when you were going through the slides, in particular, regarding the reporting periods, you noted that the—there was a typo, actually, on slide 14 in regards to the 2018 to 2020 payment adjustment year. Does that actually carry back all the way through slide 10?

Travis Broome: Yes. It appears it does. Yes.

Denise Sharma: OK.

Travis Broome: Once you're past your first year, it's always 2 years apart.

Denise Sharma: OK. That's what I thought I heard. Thank you.

Operator: Your next question comes from Irene Redding.

Irene Redding: Yes. Hi. My question is regarding the hospital-based physicians. I just wanted to clarify. If you know you're hospital based, do you still have to register with the program? Or will they, you know, go by the claims that you submit for the (inaudible)?

Travis Broome: No, you do not. We—you know, we'll take the list that's behind what we used to tell when you register. So you do not have to register. Registration is just the method you have to verify that you are, indeed, hospital based. So, you know, if you didn't want to bother to register, say, your hospitalists who spend all of their time in the inpatient department only, you wouldn't have to do that.

Irene Redding: Okay, well, I'll . . .

Travis Broome: One thing to watch out for, though, is to be—you know, if they do spend some time with outpatients at all, you might want to be careful. We have had some hospitalists who have been surprised that—to find out that, in reality, they spend about 25 percent of their time in an outpatient department.

Irene Redding: OK. Well, my other question is, then, now, our physician isn't a hospitalist but he's a surgeon that, you know—above 90 percent of our claims are procedures in the hospital.

Travis Broome: Yes.

Irene Redding: We have very few outpatient consultations or, you know, office visits. So that's considered hospital based. Is that correct?

Travis Broome: Yes. I mean, you're considered hospital based if, you know, more than 90 percent of your services, you know, based on, you know, individual service billing—not amounts, but just the pure number—are in either the inpatient department, POS 21, or the emergency department, POS 23. You know, where you fall, on what percentage, like I said, that's what you can find out by registering.

Irene Redding: OK. So, it would be safer to just register.

Travis Broome: Yes. I would certainly highly encourage you to find out for sure.

Irene Redding: OK. All right. Thank you.

Diane Maupai: Thank you, Travis. Hey, Travis, are you still using that headset? We're hearing a lot of people in the background again.

Travis Broome: Well, I was trying to do that because it actually has a mute button. There is no such thing as a mute button for the handset.

Diane Maupai: Sorry about that.

Travis Broome: That's all right.

Operator: Your next question comes from Michele Petrites.

Michele Petrites: Yes. I have—this is Michele Petrites. And I had a question about the hardship exemption. You had talked about the unforeseen events, and one of the things you said was closure. And, I guess I'm kind of confused about that because if it's unforeseen that you're going to close, how would you know to do that before July 2014?

Travis Broome: Well, the reason we chose the July—I mean, the July 2014 date is the last day to start your EHR reporting period and become a meaningful EHR user. So, our theory on choosing that date, the—is that it's too—you know, anything that happens after July 1st, if you aren't—weren't already in your meaningful EHR—your reporting period, then, it's too late. You know, you couldn't have—you couldn't have been a meaningful user anyway. So, if you were . . .

Michele Petrites: Right. I guess—I guess I was looking at closure, even looking toward, you know, retirement, like what is the—I noticed that there wasn't anything that was in there that had stated that, you know, you are going to be retiring within the upcoming—I noticed you gave for the new people 2 years. I didn't know if you had something that . . .

Travis Broome: There is no provision that, like, "If I'm going to be retiring in 2 years, can I just not bother with this thing?" No. There is no hardship exemption for nearing retirement.

Michele Petrites: So, really, the only unforeseen would be, you basically—is suddenly if something happened and you close and you would have to apply for that when . . .

Travis Broome: Yes. Or some other hardship—I mean, you know, one of the hardships is financial. You know, we can't really pre-judge applications. But, you know, if it was some situation where you basically—say there is going to be an extreme financial hardships, you could try an application like that.

Again, it would have to be something kind of behind—you'd have to also prove that was kind of unforeseen, uncontrollable. But—so we don't—you know, you can apply, but yes, there isn't a retirement-specific or application for it. You would—if you were going

to stress financial hardship, it would have to be something like a restructuring or things like that.

But, you know, keeping in mind, right—so, we're talking about everything's prospective. So, if you were to, say, close and retire before—in, you know, September 1st, 2014, you wouldn't be submitting any bills that would be subject to the payment adjustment anyway.

Michelle Petrites: I guess I was looking more so at retiring August '15—2015.

Travis Broome: Yes. If you're in that situation, you would just, you know, have to weigh the pros and cons of, you know, moving to EHR versus maybe taking the payment adjustment for a short time. But, like I said, that—we had folks ask for, you know, when they made the regulations, a retirement-based hardship exemption. But when the policy was made, we explicitly did not do that.

Michelle Petrites: OK. Thank you.

Travis Broome: Yes.

Operator: Your next question comes from Marvin Berkowitz.

Marvin Berkowitz: Marvin Berkowitz. So, thank you. I just want to clarify the issue, again, of the scope of practice . . .

Travis Broome: Yes.

Marvin Berkowitz: . . . for EPs. So, according to the slide 25, anesthesiologists, pathologists, radiologists, if they are registered for one of those specialties, get the automatic exemption without any kind of application. So, for the hospital-based providers, does an application have to be made? Or if you register and you are classified as hospital based, you are covered? So that, you know, the piece about surgeons and ER physicians and others who are billing but are clearly hospital based, I was still a bit unclear about.

Travis Broome: All right. So, the—we make the hospital-based determination. It's not something . . .

Marvin Berkowitz: Right.

Travis Broome: . . . that you apply for. So we will use the whole list. And so every year—at the beginning of every year, we basically run literally everyone who has billed Medicare for the past year through that calculation. And anybody who comes up more than 90 percent, they get that hospital-based status. And we will use that whole list whether you register or not. The only reason to register is not so that we know who you are . . .

Marvin: So we know.

Travis Broome: . . . but that you can confirm that you are hospital based.

And the other—I'll take the opportunity to stress here, too, is—you know, some people do end up on the bubble of the 90 percent. And that is why we went with the "either" years as opposed to just doing it on, say, the 2014, so that, you know, you wouldn't be in a situation where, say, let's say I was 91 percent in 2013. So I think "Oh, I'm good," and then it turns out I'm 89 percent in 2014, oh, but now it's too late to do anything about it. We didn't want to have folks find themselves in that situation. So, it is either 2013 or 2014. So, if you were to check today and you're hospital based, then you're golden for 2015.

Marvin Berkowitz: OK. So, as long as you have that classification, there's no application that's needed.

Travis Broome: Yes. No. Absolutely not.

Marvin Berkowitz: All right. Thank you.

Operator: Your next question comes from Russell Onken.

Russell Onken: Yes. Hello. Thank you. We are a group of radiation oncologists.

Travis Broome: Yes.

Russell Onken: Not radiologists. Radiation oncologists. Ten of our physicians are hospital based. Their entire practice is based at a hospital, a hospital that we don't own. The software in the radiation oncology department is not the same software the hospital uses to get their Meaningful Use designation or et cetera under Part A.

So, as it's currently defined, are radiation oncologists who do all their work at a hospital-based center . . .

Travis Broome: Yes.

Russell Onken: . . . using the hospital's equipment are considered eligible—you know, eligible providers and will be penalized even though we don't own the hardware or software? Therefore, we have to somehow convince the hospital to purchase the hardware, software, et cetera that meets Part B—not Part A—and have it in place in time for our docs to then demonstrate Meaningful Use on hospital-owned equipment. Why are—why are radiation oncologists not considered to be exempt?

Travis Broome: Oh, well—so, there's three pieces there that I'll go over with. So we'll kind of work backwards. So radiation oncologists aren't considered to be exempt because

when you go to the Board of Radiation Oncology and read the standards of practice, there's patient interaction and followup all over the place.

So anesthesiology and radiology and pathology get the exemption not because they're radiology or anesthesiology or pathologies but because their standard practice doesn't really involve a lot of followup and doesn't involve much face-to-face, if any, patient interaction. Anesthesiologists obviously see the patient but that's a very unique interaction. So that's not whether or not in that group.

But in your situation, you're not really interested in that one, primarily, like you said. You know, obviously, lots of followup, moving on. Radiology oncology is very much a followup and interactive thing. But the lack of control exception it sounds like is what you're talking about in yours.

So, you have this—you have this group of radiology oncologists. They—sounds like they do—you know, they're in your group. They just happen to do their work at this hospital thing. You know, sounds like they might get their professional fee, the hospital gets the facility fee, you both go your merry ways. Your guys just do their professional thing at this location. So, I would—you know, listening to your circumstance, where you would—if you are applying for a hardship, you would most likely be applying under lack of control over the availability of, like you said, ambulatory certified EHR technology.

In your—assuming you continue your efforts to convince them to make EHR available, I would point that there's only two differences between an ambulatory certified EHR technology and an inpatient certified EHR technology. And those are e-prescribing and patient office visit summaries. So the leap isn't as high as it might seem when you're thinking about those separate systems. But, again, it sounds like you're in a classic lack of control situation for those guys.

Russell Onken: Yes, but that doesn't solve the issue. They are two—they have to be—one is an oncology software. And, basically all the hospitals with radiation oncology departments have unique oncology software.

But the other is, it makes us have to apply for an exemption each year. And as I understand it, you can only do that for 5 years, and then you're no longer able to apply for exemptions. So at some point, we're going to be penalized if the hospitals don't purchase certified Part B software and hardware for their radiation oncology departments. So, it really—you know, the solution isn't for us to apply for exemption. All that would mean this year is we wouldn't be eligible. If we could convince them to do it all and accomplish the 90 days, we could get incentive. But now if we apply for exemption, we're taken out of that opportunity, and we're strictly going forward in the penalty situation. And, again, every year we're going back to the hospitals to convince them to purchase this for our use even though we don't own it.

Travis Broome: Yes, unfortunately, for the timeline piece, you know, you mentioned you can only get it for 5 years and the incentive—last year to start to earn incentives is 2014.

That's set in statute, unfortunately. So there's not anything CMS can do about the 5 years or to lengthen out the incentive because that would require a legislative fix.

Beth Myers: This is Beth Myers from CMS. I'd also want to add—I understand your frustration. But I do want to mention that there are some provisions that might make making that argument a little bit easier.

As Travis mentioned, there's only a couple pieces that would be required to make it so that it fit what your full need would be to meet Meaningful Use for those physicians.

However, there's also changes to how O&P does certification. So, they wouldn't even necessarily have to purchase a new system. You're now allowed to do modular certification. So all you would need is a module that would allow you to input that data in that fashion, that would be for your use, that could be part of the overarching system or apply for certification for that independently. And a lot of the cost would be significantly reduced by taking that particular route.

So, I do understand your frustration. I'm just saying that there are some options that make it not quite as daunting as it might currently seem.

Russell Onken: I'm thinking you don't understand how the software and hardware situation works in radiation oncology. There are three systems that are approved for Meaningful Use. And you have to have one of those three systems in the hospital. And so the hospital—most of them have some version of that, an older version. And they have to upgrade—they have to put in place most of what—they have to put in place . . .

Diane Maupai: Excuse me. Excuse me. This is Diane Maupai. I appreciate your frustration. But I think we've given you the answers that we can for right now, and we'd like to give some other people a chance to ask a question, please.

Operator: Your next question comes from Bernie Siryk.

Bernie Siryk: Yes. Bernie Siryk. Thank you very much. My question pertains to slide 27 in terms of when will the details on applying for a hardship exception be posted. Do you have a target date for that?

Travis Broome: Sure. The—we hope to get that up for hospitals, since they have 3 months (inaudible), later this year. So probably, you know, kind of November-ish. And the goal is to get it up for EPs at the very beginning of next year. So, hopefully before January is out.

Bernie Siryk: OK. And then, just a very quick followup: I know I've got to get back in the queue. But do you have a sense of how long the review process might be once a hospital submits?

Travis Broome: It will probably vary depending on which one you are going for. So if it was something, you know—like infrastructures, you know, probably something pretty easy to demonstrate, you know, through quotes and providers and stuff. Our hope would be that it would be fairly quick for most—you know, call it 2 weeks. You know, obviously, if it was something strange, with unforeseen circumstances that we have never encountered before, and there was lots of kind of back and forth between us and you trying to figure out what's going on, that would obviously lengthen the process.

Bernie Siryk: OK. Thank you very much.

Operator: Thank you. Your next question comes from Jackie Kravitz.

Jackie Kravitz: Hi. Thank you so much. Can you hear me?

Travis Broome: Yes, we can hear you.

Jackie Kravitz: Oh, good. OK. My question is, if you apply for and achieve a hardship for e-prescribing because of whatever reasons, how is it, then, that you have to meet the e-prescribing component of Meaningful Use in order to successfully attest?

Travis Broome: I don't know, Beth, if you're more familiar—I'm not familiar with the—what all the various hardships of an e-prescribing is. I know one of them is "I'm trying to do Meaningful Use." The most basic hardship, "I don't write prescriptions," is also an exclusion within Meaningful Use for the e-prescribing objective.

Beth Myers: Right. That's what I would answer, too, that if you're—if you are eligible for a hardship for the e-prescribing program, then you're likely can claim an exemption from that particular Meaningful Use measure, which is one of the options in the attestation system that would allow you to meet Meaningful Use because you would fulfill all of the other requirements that that—that that would be—that you didn't have the patient volume to have that even meet the threshold.

Jackie Kravitz: Perfect. Yes. We applied for the hardship. We get the hardship, and then I went to go attest and I was a little confused. I didn't realize I could exempt that. So, thank you so much.

Operator: Your next question comes from Linda Walling.

Linda Walling: Hi. This is Linda Walling. Thanks for taking my question. It has, again, to do with the hardship exemption where there's not control over certified EHR technology at the facility. We have, essentially, a virtual clinic of geriatricians who only attend patients in skilled nursing facilities and transitional care units. And these are not owned by our organization. They are community based and privately owned. And that's their entire practice.

And very few if any of these facilities have a certified EHR. Because the physicians are there frequently, many of them have medical director roles at these facilities. Is that going to be considered a management position, where they would be presumed to have some sort of control over whether the facility chooses to spend their money on an EHR?

Travis Broome: Well, like I've said a few times already, we really can't pre-judge any actual application for that. I mean, you know, if they did have some kind of role, like you said, a medical director there, you know, a lot of whether or not they have any control would be, you know—does the agreement to be the medical director involve any purchasing clout or purchasing decisions, or are those explicitly reserved?

I mean, I think to some extent, it would depend on what their actual job—you know, the agreement would be between—as far as serving as the medical director. Just because they serve as a medical director certainly would not be an automatic disqualifier.

I mean, those were—those are just examples, kind of things to think about that I was giving. They're not hard lines, where if you're on this side, you therefore will not get it, and if you're on that side, you therefore will get it. I was just trying to give some examples of situations. But, certainly, your situation we'll add to that list, you know, nephrologists working in ESRD facilities, the gentleman who talked about radiation oncologists working in hospital outpatient departments, surgeons in ambulatory surgery centers—you know, those are exactly the types of situations why we created this exemption.

So, again, you know, if they do have a role like that, you would certainly want to describe how that role does not involve the ability to, you know, make purchase decisions about systems and things like that, because obviously it would inherently raise a flag in review of the applications. So, you'd want to head that off at the pass. It can certainly be headed off at the pass, though.

Linda Walling: OK. Thanks very much.

Operator: Your next question comes from Kara Andrews.

Kara Andrews: Yes. This is Kara Andrews. I work for a gynecologist and an orthopedic surgeon with private practices. And I'm a bit confused on slide 26, under the lack of control over CEHRT, the very first bullet point. I'm unsure, since our surgeons do operate at outpatient facilities, if that would—if we would fall under that or not. Can you explain that and go into further detail with that first bullet point?

Travis Broome: Sure. So the first bullet point has to do with a provision we have in Meaningful Use. So when you look at your outpatient encounters, you know—so, whether or not I'm eligible for Meaningful Use, can I even go for the incentives?

I have to have at least 50 percent of my patient encounters at outpatient locations with certified EHR technology. If it's 50.001 percent or 50 percent even or 51 percent or

70 percent of my outpatient encounters are at locations that have CEHRT, when I do my Meaningful Use, I just get to ignore all the other ones.

So, let's go with, you know, your ob-gyn. So, let's say they do work at, you know, an outpatient department, but that's only 20 percent of their work. Everything else is in the office or in the hospital—or the nursery. They would just basically say, "Well, we can ignore that because it's less—because we meet that 50-percent threshold."

So, if you meet the 50-percent threshold with outpatient encounters at locations that have EHRs, then you can ignore the rest, and you can do Meaningful Use and life is grand. If you don't meet that 50-percent threshold, then you're not eligible to do Meaningful Use. And then it becomes—then you're now potentially eligible for this hardship.

So you meet that first bullet, and then we move on to whether or not you meet the lack of control aspect.

Kara Andrews: Wonderful. Thank you very much.

Travis Broome: You're welcome.

Operator: Your next question comes from Lee Edelman.

Lee Edelman: Lee Edelman. We demonstrated successful Meaningful Use in 2012. When do we need to do it again?

Travis Broome: You need to do it again for a reporting period of all of 2013. And then you would actually do the physical actual attestation in the first 2 months of 2014.

Lee Edelman: In the first 2 months of 2014.

Travis Broome: Yes.

Lee Edelman: OK. Very good. Thank you for your help.

Travis Broome: You're welcome. And that will, obviously, avoid the 2015 payment adjustment and—as well as getting your incentive for 2013.

Operator: Your next question comes from Harlan Epstein.

Harlan Epstein: My question's been answered. Thank you.

Operator: Your next question comes from Lu Hersey.

Lu Hersey: Hi. This is Lu Hersey. My question is, for physicians that are in private practice—private group practice in 2013, but they—and they have not attested. In 2014, you have one or two leave to join other entities, whether it's faculty or a foundation or

some other entity. Do those physicians still have to either go for the hardship before July if they're joining new entities? Or does it depend on how they join them?

Travis Broome: Yes. They need to either meet Meaningful Use or apply for a hardship no matter which entity they were going to. This has been one of the toughest spot—things both for us in implementing the law and then for the public to understand. But the law does—doesn't even address who employs physicians at all. It's completely ignored.

So, who your physician works for, how they work for them, when they work for them, the terms of their contract—all of that is completely outside the scope of the program—the legal authority we have under the program. So, their status follows the individual eligible professional, you know, for the most part physicians, no matter where they go.

Lo Hersey: So, as a group administrator, if you're bringing on a physician, then you'd need to know where they stand in terms—even if they're reassigning their Medicare benefits to our entity.

Travis Broome: Absolutely.

Lo Hersey: OK. All right. Thank you.

Operator: Your next question comes from Mary Dobruck.

Mary Dobruck: Hi. I have a—I am doing the billing for nurse practitioners. And we are unclear whether we were eligible for incentive. In the work that we do, we go to various nursing homes and do wound care consultations. So, who can I speak with directly—because I'm sure you don't want to take up everyone's time talking about my particular issue—who can I speak with to talk about my practice and how it works?

Travis Broome: Sure. So you would only potentially be eligible under Medicaid, so you don't have to worry about the payment adjustments at all.

Mary Dobruck: OK.

Travis Broome: And to the extent you wanted to go after the Medicaid incentives, which are substantial and do have a longer timeframe, you can start as late as 2016 to earn those.

Mary Dobruck: Yes.

Travis Broome: I'd just encourage you to go to our website, which is cms.gov/ehrincentiveprograms. And we have a list of all the contacts for all the State programs. The States run the Medicaid side of this program. And that will give you the contact for whatever your State is, and you can talk to them about how best to figure out—since you are in nursing homes, you probably are eligible from that—from the patient volume perspective, so just whether you can actually meet Meaningful Use.

Mary Dobruck: But from Medicare there's no eligibility whatsoever.

Travis Broome: No. Nurse practitioners are not eligible professionals for Medicare.

Mary Dobruck: All right. All right. Thank you.

Travis Broome: You're welcome.

Operator: Your next question comes from Melissa Unger.

Melissa Unger: My question's already been answered. Thank you.

Operator: Your next question comes from Jodi Dierich.

Jodi Dierich: Yes. I'm wondering, under slide 26 again, we have physicians who are contracted 1 day a week in our office.

Travis Broome: Yes.

Jodi Dierich: And they practice, obviously, in multiple other locations. How do we determine if they provide at least 50 percent of their patient encounters at a place that does not have ERT?

Travis Broome: You're probably going to need information from them. This is—this is exactly the type of situation I was hinting at when—the law not taking into consideration those types of situations. It's been operationally difficult for both us and for the—for you all as group administrators. I don't—I don't have a magic bullet for you on that one.

You're just certainly going to have to work with the individual physicians to find out, you know, where they go, do those locations have EHR or not, because, again, the Meaningful Use, you know, kind of by statute, is very dependent upon their—the totality of their actions, not the subset that occurs at any particular group or practice, or whatever you want to call them—the organization.

Jodi Dierich: So, the totality of all of their encounters in all of their practice locations.

Travis Broome: At all of their outpatient practice locations. Yes.

Jodi Dierich: Right. OK. And then on those same lines, if, let's say, their primary location that we contract with for their service—let's say that they've applied for the incentive.

Travis Broome: Yes.

Jodi Dierich: They qualify for that. Can we, then, also apply for an exemption from the penalty?

Travis Broome: No. I mean, if they've got—if they've earned the incentive—you know, if that—if that individual has earned the incentive, they're unlikely to have the adjustment applied to them. So there wouldn't be anything you would need to be exempted from.

Jodi Dierich: So, if that other location applied and was approved for the incentive payment, they will get the payment. We won't get the payment but we also will not see a penalty on our end.

Travis Broome: Right. Yes. Because, again, you know, when this file is run both on the incentive on the payment adjustment side, it's strictly done by the individual national provider identifier number. There is—there isn't even information to use about which particular practice they might be at.

Jodi Dierich: OK. Great. Thank you.

Operator: Your next question comes from Danny Picart.

Danny Picart: Hello. This is Danny Picart. I'm calling you from the Ponce School of Medicine in Puerto Rico. My question is in regards to the slides and also subsequent information that you will be publishing under this same subject. Are you planning on publishing it to a specific site? And are you publishing a new set of slides with the corrections made to the errors you found?

Beth Myers: This is Beth Myers from CMS. Yes, we will publish this. We will correct the errors. It will be on the National Provider Call site. Diane, I think we can try and get you a corrected version if we can make that swap at some point. But we will also post it on two locations. I'll spell out what the URL is right now. One is www.cms.gov/ehrincentiveprograms. And then when you get to that site, there's a tab on the left-hand side that says "Educational Resources." And it will be under that section.

And then we will also post it on our E-Health website, which has information on various programs, as well. And that is www.cms.gov/ehealth, so it's slash e-health. And again, there is an Educational Resources tab. It will be on that section.

Diane Maupai: Let me add to that. This is Diane. On slide 27 at the bottom, you will find the link to the EHR website. And then, as Beth said, you'll go to the left and you'll look at Educational Resources.

Danny Picart: Thank you.

Operator: Your next question comes from Anthony Koo.

Anthony, your line is open. If you have your own phone muted, please unmute.

Anthony Koo: Yes. Sorry. This is—yes. This is Tony Koo. I am one of the anesthesiologists in a big anesthesia group. And I know that we're exempt, but I had a question about if we do take the initiative to be MU certified, are we—are we not—are we taken out of the exemption after we take the money?

Travis Broome: No, you're not. So, it is potentially a kind of have-your-cake-and-eat-it-too situation for you. The law called for a significant hardship in being a meaningful user. And we judge those three specialties to have significant hardships to being one.

But if you can overcome those hardships and become a meaningful EHR user, we are very happy to hear that, and more power to you. And you will get the incentive money. And also you—you know, for some reason, you know, your practice changed, and you were no longer able to meet Meaningful Use, you would still get the hardship, as well.

Anthony Koo: OK. Just kind of a followup to the certification for MU, then—the requirements. What is the email from the patient? What is that? Why is that necessary, especially for an anesthesiologist? I just didn't see what we could use that for.

Travis Broome: Secure messaging communication back to the anesthesiologist. Well, you know, part of the reason you have a hardship was—or were eligible for the hardship is Meaningful Use isn't particularly well tailored to your specialty. So we—we could—how that might work out for an anesthesiology is probably not something I could kind of answer on the fly. But, yes, that certainly would be one of the areas that would be a little weird, I would agree, for an anesthesiologist.

Anthony Koo: OK. Well, thank you so much.

Travis Broome: No problem.

Operator: Your next question comes from Kelsey Bergman.

Kelsey Bergman: Hi. This is Kelsey Bergman from Spectrum Health. Referring back to slide 8, I believe I heard that if you haven't been a meaningful user, that you could submit in 2014 using any 90 days. And I was just wondering if that's true, or if it needs to be tied to the calendar year quarter.

Travis Broome: The only—it is true. If you've never—if you're a first time meaningful user, you can do for any 90 days. The calendar quarter is just for those folks who have previously demonstrated Meaningful Use in either 2011, 2012, or 2013.

Kelsey Bergman: All right. Thank you.

Operator: Your next question comes from Kristen Flygare.

Kristen Flygare: Hi. My name is Kristen Flygare, and I'm calling from St. Cloud Medical Group in St. Cloud, Minnesota. We have a provider who was with our practice and

attested for Meaningful Use successfully in 2011, then left our practice and went to work at the VA in our community, and is now coming back to us next month. So my question is, what do I do with him? I can get him for Stage 2 next year along with everybody else.

Travis Broome: Yes.

Kristen Flygare: What can I do for him this year so that he doesn't have a penalty in 2015 when he's only going to be practicing with us for 2.5 months?

Travis Broome: Got you. So, basically, he needs—individually, he needs to have a full-year reporting period. So, again, you know, this was kind of one of those situations, like I was talking about earlier. There's really no—there's no special provision for individual guys switching employment like that. And, I guess, the—you know, it would kind of be a stretch to call them uncontrollable.

But really, the only thing I could think of for him, you know, assuming he didn't work at one of the few VA facilities that have certified EHR technology. If his facility is one of the ones that has the certified version of Vista, well, you just get the data from the VA, combine it with your data, and attest and move on. Assuming his system wasn't one of the VA facilities with a certified version of Vista, you know, you could potentially go for the kind of lack of control hardship, if you would, you know, so that he practiced at an outpatient location, in this case the VA, for 80 percent of the year. He had no control over whether EHR was available and therefore he wasn't able to meet it.

Kristen Flygare: OK. So you made the getting the information from the VA sound very easy, which I don't think it will be. But, that's my best—that's my best shot?

Travis Broome: I understand the difficulties there. Unfortunately, we don't have any legal mechanism. We've kind of shamed some practices before into turning over the information, but I certainly have no legal stake to force an organization to give information to another.

Kristen Flygare: So, my options are, just to make sure I understand, to get information from them and combine it with whatever I have and attest for the year.

Travis Broome: Yes.

Kristen Flygare: Or to find out if they don't have certified, and then I can just apply for the hardship. Or if I can't get information from them and they do have certified, then we just have to kind of eat it and take the penalty in 2015.

Travis Broome: You understand the situation.

Kristen Flygare: OK. All right. Thank you.

Operator: Your next question comes from Melanie Johnson.

Melanie Johnson: Hello. This is Melanie Johnson with the office of Wilbert Stock. We are a solo practice of optometry. We file Medicare and Medicaid claims. And on page 24, you have the scope of practice, and I had some questions in regards to it.

We do see our patients on a face-to-face basis.

Travis Broome: Sure. Yes. I mean—yes. Go ahead. Continue. Sorry.

Melanie Johnson: OK. We do see our patients on a face-to-face basis. But a lot of them, you know, are seen, they are prescribed glasses, and they leave the office. We don't see them back—some of them, for a year; some of them for more than that. And then, we do bill EM codes. And you were saying that that is a red flag? And I'm not sure what you meant by red flag for the EM codes.

Travis Broome: I—yes, you're welcome to apply. Like I said, I can't really pre-judge applications. But I see no way that an optometrist would be eligible for that exclusion. You know, many of your patients, you will have followup needs. You know, any of the ones with glaucoma or anything.

You know, like you said, they do come back once a year, you monitor their progress, you see them face to face, you do evaluation and management. I mean, I would be—yes, you would have to—if it was just a normal optometry office, I mean, I can fairly well say—like I said, we can't officially pre-judge any application, but you're not going to meet this exclusion. I mean, this is just . . .

Melanie Johnson: So what did you mean by red flags on the EM codes?

Travis Broome: Well, you know, providers who do evaluation and managements, you know, typically would need that kind of patient interaction in order to do that evaluation and management. You know—so that—so if you say you don't have patient interaction but you're billing E&M, those two things, you know, in most cases, are at—at conflict. So that's why it would be a red flag.

Melanie Johnson: OK. Thank you.

Operator: Your next question comes from Korina Brooks.

Korina Brooks: Hi. Korina Brooks here. We attested for October, November, December 2011, and unfortunately missed the first year of reporting that would have been had to be done by February 2013.

Travis Broome: Yes.

Korina Brooks: Now, are we going to be subject to the 2015 penalties? Or are we able to attest by February 2014 to avoid the 2015 penalty?

Travis Broome: You'd attest for—so basically, you missed out on your 2012 year. That—you know, sorry to hear that. But that only affects your incentive. So at the end of 2013, when you've done your full year for 2013, you attest in January or February of '14, and then that would avoid—that would both get you the incentive for 2013 and then avoid the payment adjustment for 2015.

Korina Brooks: Perfect. Thank you very much.

Operator: Your next question comes from DeeAnne McCallin.

DeeAnne McCallin: Hi, Travis. This is DeeAnne McCallin from CalHIPSO REC. And, question about slide number 8 for—they have to—if they've been a meaningful user in 2011 or 2012, the deadline you have is the February, which we spoke about, 2014.

Travis Broome: Yes.

DeeAnne McCallin: But if they're Medi-Cal Medicaid providers, that's not their deadline. So does the attestation have to be per the Medicare tail?

Travis Broome: Good point. I got caught being Medicare-centric on my slide. So, some—what she's referring—what DeeAnne is referring to is that the—some States have longer windows with which to attest to the Medicaid program—3 months instead of 2 months, for instance, I believe, is the case in California. And if your State does give you a longer window to attest, that's fine for that 2013 day.

Now, for the October 1st, 2014, that's the last date for everyone. You know, you can certainly attest. You can be in a weird situation, just kind of—I'll take this opportunity to give this heads up. So, you could find yourself in this weird situation that you could do 90 days, if you wanted to, from October 1st to the end of the year of 2014 and attest, say, January something '15—2015 to Meaningful Use. You would not avoid the payment adjustment in 2015 because, like I said, we have to know ahead of time, but you would actually get the incentive for 2014.

So, you can find yourself in a weird situation like that in 2014. But, as far as—as long as it's before October 1st, 2014, if the State gives you more time—if the State gives you more time, then that's fine.

DeeAnne McCallin: Great. Thanks.

Operator: Your next question comes from Melanie Robin.

Melanie, your line is open. If you have your own phone muted, please unmute.

Her question has been withdrawn.

Your next question comes from Justin Williams.

Justin Williams: Hi. Justin Williams with DaVita. So my question, Travis, is can EPs still qualify for the 50-percent hardship exemption for no control if they can bring their certified EHR technology to those locations that don't have certified EHR technology?

Travis Broome: Yes. So, this is a wonderful virtual world now. So the short answer to your question is yes. There is an FAQ that is available and out there that talks about, you know, ways you can equip this—a location with certified EHR technology. And one of the ways you can equip to get—to earn the incentive is to bring your tablet, bring your, you know, your iPad, bring your laptop or whatever, and essentially, do dual recordkeeping at the location.

The location is going to have their own requirements. You said you're at DaVita. So the ESRD facility is going to have their own requirements. And I'm going to document here, and then I'm going to turn around and I'm going to put the same information in my laptop.

When I'm trying to get the incentive, we say, OK, that's, you know, not ideal, but it works. For the payment adjustment, since that's a much different dynamic, you can say that the location isn't equipped even if you have a portable EHR. If the location is requiring recordkeeping—you know, all locations have to have some kind of recordkeeping. And if they're doing it not using certified EHR technology, you can say that that location is not equipped even if your own EHR back at your office is technically portable.

Justin Williams: Got you. OK. Thanks. That helps. So the nephrologist could be in that kind of have-your-cake-and-eat-it-too situation because they could have gotten a year or 2 or 3 of incentive and then turn around and apply for the hardship exemption if they—if they so desired.

Travis Broome: Exactly. Yes. They could be—and it's the same thing like we were talking about with the anesthesiologist of, you know, if you have the significant hardship, and if you overcame it by doing dual recordkeeping and bringing your laptop on site and doing all that stuff, you know, that's something we want to reward, not penalize.

Justin Williams: OK. All right. Thank you, Travis. I appreciate it.

Operator: Your next question comes from Heidi Harting.

Heidi Harting: Yes. Hi. My name is Heidi Harting, and we are considering switching EHRs, which is a huge undertaking.

Travis Broome: Yes.

Heidi Harting: Many of our providers have already been attested in 2011 and 2012 and are continuing in 2013. Therefore, they would have to do a quarter in 2014 or the 90 days.

Travis Broome: Yes.

Heidi Harting: And it may be very difficult to meet that quarter in particular. The 90 days maybe gives a little flexibility, but that quarter. Would that—what would—is there a hardship that you would recommend with the . . .

Travis Broome: Yes. So this is an issue that started to come up a lot frequently. Unfortunately, it didn't come up when we were doing the regulation. And that is, you know, for whatever reason, someone—the hospital, doctors—have just chosen to switch EHR developers.

As you pointed out, that is a huge undertaking and not something undertaken—that would be undertaken lightly. So presumably there was, you know, a very good reason, probably out of your control—and you can probably tell where I'm going with this now—that you chose to do that.

So, I certainly would encourage you to apply for a hardship exemption under the, you know, unforeseen or uncontrollable circumstances. And, you know, the application would probably look something along the lines of "We made the decision to switch because of these reasons, and the switch is coinciding with this EHR reporting period. So we're asking you for a hardship exemption for this particular period and for this particular year, and then we'll be back on EHR and rolling all through next year."

Like I said, that wasn't something to come up a lot in the rules, so it's not a specific example in the rule. But it is something that has been coming up a lot lately. I certainly would encourage you to apply. And we'll probably be coming out with some kind of more guidance on that particular situation for folks in the near future to kind of guide those applications.

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

Operator: OK. Our final question comes from Eileen Feinerman.

Eileen Feinerman: Yes. Thank you. This is Eileen Feinerman with Dr. Terence Peppard in Miami. We have a kind of unusual situation where, like you mentioned, sometimes you come in as hospital based at, you know, tweaking in just under the number. We were 87 percent last year.

Travis Broome: Yes.

Eileen Feinerman: So most of his services are in the hospital. He's a private practice physician seeing patients in the hospital setting. And a tiny little percentage of his patients have followup in an office setting.

Travis Broome: Yes.

Eileen Feinerman: Because the office setting is so tiny—our office practice is so tiny, we simply rent two—rent space 2 afternoons a week, sometimes not even filling up 2 afternoons a week. And, you know, to—and, like subleasing space.

Travis Broome: Yes.

Eileen Feinerman: So we certainly don't have control. We can just about stand there and, you know, see the patients. We don't have, you know, lots of control over what we do there. It's a surgeon's office who's out of the office that's . . .

Travis Broome: Yes.

Eileen Feinerman: . . . you know, leasing space to us. Would we qualify, then, for having little or no control? I mean, I—like you mentioned, you could bring a laptop. You could bring—but is that really—you know, couldn't we say that we're a tiny little outpatient, you know, office—outpatient setting, which the place of service is always 11 for those—for those . . .

Travis Broome: Sure.

Eileen Feinerman: . . . minute, you know, work—you know, workload. Would we—would we be able to, you know, to qualify in the hardship?

Travis Broome: So like I've said several times on this one, I—you know, we can't really pre-judge an application that way. I certainly would encourage you to apply for that. That is an interesting wrinkle that I hadn't heard before. I can certainly see where you're coming from, that basically you're basically saying, "Look, you know, I can't—I can't control the situation—the location in terms of—yes, you know—yes, I could buy an EHR, but I don't—you know, I can't control the infrastructure. I can't, you know—I don't have anywhere to put it," you know, that type of stuff. You know, like I said, and personally, given that particular one, much thought in—like I said, we can't pre-judge applications. But I certainly would encourage you to apply under that scenario—under the control.

Eileen Feinerman: OK. Because, you know, I wouldn't want CMS or Medicare to come back and say, "Well, rent space that you could have control over," you know. But it's such a tiny little practice that we have seeing office patients. As I said, 87 percent where—you know, for—for—you know, you mentioned that in January, I should just, you know, register again for him and see.

Travis Broome: Yes.

Eileen Feinerman: Maybe we're at 91 percent and then this whole point is moot, you know. But just preparing myself for if we do have to do Meaningful Use, you know—I mean, couldn't Medicare come back to us and say, "Well, you know, go the extra mile and rent an office that you do have control over"?

Travis Broome: They probably wouldn't say that. It'd probably be more along the lines where you have to keep your medical records somehow, some way—you should do it electronically.

Eileen Feinerman: Well, we do have keeping medical records—we do have medical records . . .

Travis Broome: But, again, you know, we'd have to see the actual application and . . .

Eileen Feinerman: Right. I understand. We do have a main office, which we do not see patients there at all. We just have—you know, we have an office, you know, where we keep all our medical records. But for convenience reasons and for other practical reasons, the doctor only sees patients twice a week for a few hours.

So—I'm not understanding, also, the verbiage of less than 50 percent of outpatient encounters. When you say outpatient, do you just mean place of service office, you know, and the like? Would we be considered—because you've mentioned before, outpatient, you know, as opposed to his office practice. But, (inaudible). Yes. OK.

Travis Broome: Yes. So, real quickly, the—if in the—yes, if the outpatient piece—so the inpatient side, we don't count that in the denominator.

Eileen Feinerman: Right.

Travis Broome: So, for you, even though he does, what was it, 87 percent in the inpatient department, that 87 percent wouldn't be in the denominator of that calculation. It'd only be—the denominator would only be those outpatient encounters—so, only 13 percent of encounters—and the numerator, for you, it sounds like it would be zero. But if you did have one location with EHR, you know, you would put that in the numerator.

Eileen Feinerman: But since we know—I mean, the—the—and the place where we rent space from, I don't know what they have for themselves, you know. That (Inaudible).

Travis Broome: Sure. And then, I think, we'll—we'll need to cut it off there. And like I said, we can follow up with you more. I'm sure somebody will give an email address here at the end.

Eileen Feinerman: OK.

Travis Broome: But—yes. I mean, for you, you know, it would be—I would encourage you to apply under control, but that would be—yes.

Eileen Feinerman: OK. OK, awesome. Thank you.

Travis Broome: You're welcome. Diane?

Additional Information

Diane Maupai: I was on mute. Sorry about that. No wonder I couldn't break in.

Unfortunately, that's all the time we have for questions today. If we didn't get to your question, please go to the EHR Incentive Programs website listed on the bottom of slide 27. You will find tabs on the left for educational materials, as well as FAQs, frequently asked questions. You'll find a lot of good answers there.

An audio recording and written transcript of today's call will be posted to the MLN Connects Call website. We'll release an announcement in the MLN Connects Provider eNews when these materials are available.

On slide 29 of the presentation, you will find information and a URL to evaluate your experience with today's call. Your evaluations are anonymous, confidential, and, of course, voluntary. We'll hope you'll take a few moments to evaluate your call experience today.

Also, I want to remind you, on slide 28, you have an opportunity to register to evaluate your MAC.

Again, my name is Diane Maupai. I'd like to thank our presenter, Travis Broome, and also thank you for participating in today's MLN Connects Call. Have a great day, everyone.

Operator: This concludes today's call. Presenters, please hold.

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