

**Centers for Medicare & Medicaid Services  
Medicare and Medicaid EHR Incentive Programs  
Registration and Attestation for Eligible Professionals  
National Provider Call  
Moderator: Diane Maupai  
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Operator: At this time, I would like to welcome everyone to the Medicare and Medicaid EHR Incentive Programs Registration and Attestation for Eligible Professionals 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. Thank you for your participation in today's call.

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

## **Introduction**

Diane Maupai: Thank you, Holley. Hi everyone. This is Diane Maupai from the Provider Communications Group here at CMS and I'll be serving as your moderator for today's call. So, I thank you and welcome to our call about Medicare and Medicaid EHR Incentive Programs Registration and Attestation for Eligible Professionals. Today, we'll be having a presentation which will cover who is eligible and the steps you need to take to earn an incentive, highlights of the registration and attestation processes, how a third party can assist you in registering and attesting, some troubleshooting tips, and helpful resources. This will be followed by a question and answer session.

Before we get started there are a few items I need to cover. The link to the slide presentation for today's call was emailed to everyone who registered around 12:40 today. If you didn't receive it, please check your spam or junk mail folders for an email from CMS National Provider Calls. The presentation is also posted on the National Provider Call page on [cms.gov](http://cms.gov). Once on that page, select National Provider Calls and Events tab on the left hand side, and then find the entry for today's call. If you scroll down, you'll find the link in the presentation section. It's an important page because all post call materials will be located there.

As Holley mentioned this call is being recorded and transcribed. An audio recording and written transcript will be posted to the CMS National Provider Calls and Events page. I'd also like to thank those of you who submitted questions when you registered for today's call. Your questions were shared with our speaker today to help prepare remarks for the presentation.

Also, mark your calendars for our next call which will be held on Wednesday, June 27th from 2:00 to 3:30 Eastern Time. CMS and the Office of the National Coordinator for Health IT will jointly present on EHR Incentive Programs and certified EHR technology. It should be a good call.

At this time I'd like to introduce our CMS speaker for today. We're pleased to have with us John Allison. He's a health insurance specialist in the Center for Medicaid, CHIP, and Survey and Certification. Thanks, John.

## **Presentation**

John Allison: Great. Thank you, Diane and welcome everybody. Good afternoon and I suppose good morning to those of you out west, at least farther west than where we are on the East Coast. Again, welcome to this call and just before we, I believe, dive into the agenda, I wanted to say how pleased we are with the results that we've had so far for both the Medicare and Medicaid EHR Incentive Programs.

From these programs, initially launching in January 2011 when the Medicare EHR Incentive Program opened for registration and the first 11 states opened their Medicaid EHR Incentive Programs for registration, we have, through April, now dispersed more than \$5 billion in incentives. We have more than 238,000 eligible professionals and eligible hospitals registered for the incentive programs. Of, course the vast majority of that figure is eligible professionals. We have dispersed incentives to more than 57,000 Medicare-eligible professionals and to almost 37,000 Medicaid EPs.

So we consider this quite a success, and so far with 2012, we are actually leaving 2011 in the dust as far as EP participation and registration and CMS and the states getting incentive payments out to eligible providers. So right now we have 44 states that have active EHR Incentive Programs. We are hoping that on the Medicaid side even more EPs will be participating when the remaining states launch later this summer or at least later during this fiscal year.

So things are going great, but we need to have calls like this because there are many, many eligible professionals who are curious about the program, who

can benefit from an incentive, who are using certified EHR technology or are in the process of acquiring it, and who need to know about this program. So we're going to go ahead and dive into our agenda then.

So let's go to slide two. This is the agenda and Diane already talked on this. We're going to discuss the path of payment. So who is eligible for the incentive programs, both Medicare and Medicaid? How do you register? How do you attest? What is the payment process? We are going to touch on highlights of the registration and attestation processes.

So essentially what we're going to do is look through the CMS Registration and Attestation system. We're going to walk you through screenshots for registration and attestation just so that you can know, you know, on the head what the steps are, you know, the information that you have to complete in our CMS R&A system, as we call the Registration and Attestation system.

As Diane indicated, we're going to talk about third party proxy. CMS does allow third parties with the permission of an eligible professional to register and to attest on behalf of that EP. We're going to discuss troubleshooting and other resources and then we'll have the Q&A session at the end. So that is slide two, that's our agenda.

So slide three now. This looks at who the eligible professionals are. So we have a Venn diagram here. On the Medicare side, EPs who are eligible only for Medicare EHR incentives are doctors of podiatry, chiropractors, and most doctors of optometry. We're going to come back to that.

On the Medicaid side, the eligible professionals who are only eligible for the Medicaid EHR Incentive Program are nurse practitioners, certified nurse midwives, and physician assistants whenever they are working in a Federally-qualified health center or rural health clinic that is led by a physician assistant. So we can just say physician assistants under certain circumstances.

And then we do have optometrists in three states right now that are also eligible for the Medicaid EHR Incentive Program. Those states are Kentucky,

Ohio, and Illinois. So again as a general rule of thumb, optometrists are only eligible for the Medicare EHR Incentive Program.

These three states have leveraged their state plans, which essentially are the contracts between the state Medicaid agency and CMS regarding what services the state will cover, and they have covered in their state plans optometry services as adult physician services. So for optometrists in those three states – Kentucky, Ohio, and Illinois – they are considered providers of physician, adult physician services so they can come in then under the Medicaid EHR Incentive Program.

Then we have the vast majority of physicians – whether MDs, DOs, dentists – who could be eligible for either the Medicare EHR Incentive Program or the Medicaid program, but you cannot receive incentives under both programs in the same year. So again, if you find that you are eligible – if you discover that you are eligible for both the Medicare and the Medicaid EHR Incentive Programs, you have to choose between one or the other for any given year. You'll want to just consider the eligibility criteria and what it takes to receive an incentive.

But generally under the Medicaid EHR Incentive Program, a provider – an eligible professional - can receive a higher total possible incentive. That's under the Medicaid EHR Incentive Program, and eligible professionals can participate for up to six years and receive \$63,750 at most in total incentives. Whereas under the Medicare program, an eligible professional can participate for up to five years and receive a maximum amount of \$44,000 in incentive payments unless they're also working in a health professional shortage area in which they're entitled to an extra 10 percent on top of that \$44,000. So again, just something that you as eligible professionals will have to consider. So that is slide three.

Slide four. Now this, just think of the text of what we were just looking at, at the Venn diagram. Medicare-eligible professionals again are physicians, whether MDs, DOs, dentists, optometrists, podiatrists, or chiropractors. They have to have Part B Medicare allowed charges. The incentive itself is equal to 75 percent of Medicare EPs' Medicare Part B allowed charges up to a

maximum allowed charge of \$24,000. So again in calendar year 2012, a Medicare EHR an – a Medicare EP can receive at most \$18,000 in 2012 under the Medicare EHR Incentive Program.

Eligible professionals can't be hospital-based. What we mean by hospital-based is – we consider you hospital-based if 90 percent or more of your services are performed in a hospital inpatient setting or an emergency room setting. And we determine where your services are provided by looking at claims. So if your claims show a Place of Service 21, we know that's a hospital inpatient. If they show a Place of Service 23, we know that's an emergency department setting. So again, you cannot be hospital-based.

As a Medicare EP you have to be enrolled in the Provider Enrollment, Chain, and Ownership System, what we call PECOS. That's a CMS system. And you have to have an approved status in the PECOS system. PECOS is the CMS system, that's how we register Medicare providers and how we pay providers.

You also, of course, have to have a National Provider Identifier, which you can get through the National Plan and Provider Enumeration System, or NPES, another CMS system. But you have to be living. We do check the Social Security administration death master file to make sure that you are alive. Also if you're not sure whether or not that you have an approved enrollment record in PECOS, then you can go online to the CMS PECOS system and look that up. So that's for the Medicare-eligible professionals.

For the Medicaid-eligible professionals, again you can be a physician. Primarily we are talking about MDs or DOs, but also in the case of those three states of Kentucky, Ohio, and Illinois you can also be an optometrist and you're considered a provider of adult physician services and you can qualify for a Medicaid EHR incentive.

You can be a nurse practitioner, a certified nurse midwife, a dentist, or a physician assistant who is working in a Federally-qualified health center or rural health clinic that is led by another physician assistant.

Much like the Medicare program, you cannot be hospital-based if you're Medicaid EP. You have to be enrolled as a Medicaid provider with your state Medicaid agency, or with the state Medicaid agency which you are attesting for an incentive.

You, let's see, you do not have to be in the CMS PECOS system, that's only for Medicare providers and for hospitals. And again you have to have a National Provider Identifier and again you have to be alive. So those are the eligibility categories for Medicaid EPs.

On to slide six. So to register for the EHR Incentive Programs, you can visit the CMS EHR Incentive Programs website. You can click on the Registration tab and you complete the registration, and here we give the CMS EHR Incentive Programs website.

You can actually register even if you're not enrolled yet in PECOS or if you have a non-active status in PECOS. Again, if you need assistance in determining whether or not you're enrolled in PECOS in an approved status, you can go to a tool that we have at the EHR Incentive Program website. It is called the Medicare EP PECOS Notification Documents, and review that. It's available as a download on the Path of Payment tab at our website. You also don't have to have a certified EHR yet to register. So we do encourage you to go ahead and register.

Here the next slide, this is slide seven. This is for Medicaid EP registration. So if your state hasn't launched its Medicaid EHR Incentive Program yet, you won't be able to register. But right now we do have 44 states that have active EHR Incentive Programs and actually 43 of those have already begun to disperse incentives. States have been launching their EHR Incentive Programs on the first Monday of the month. So actually coming up in July, we anticipate that Virginia is going to launch its Medicaid EHR Incentive Program. So we will be up to 45 states then.

Check your state's Medicaid EHR Incentive Program website for details regarding your state's timeline if they haven't launched their incentive program yet. And I'll tell you right now the states that haven't launched their

incentive programs – besides Virginia, it's getting ready to launch – they are Idaho, Nevada, Minnesota, Hawaii, and New Hampshire. And again we anticipate that most of these states will be launching this year.

So at the Medicaid – at the CMS EHR Incentive Program website, you can go to the Medicaid State Information page or tab, and there's a tool that shows when each state has reported that they intend to launch their incentive programs. So again you can go either to your state's website or you can go to the CMS EHR Incentive Program website to find out if your state has launched, or if it hasn't, when it is planning to launch.

Also as a Medicaid EP you will register through the CMS Registration and Attestation system. And then after you complete registration through the CMS system, at that point you would go to your state's EHR Incentive Program portal in order to complete eligibility verification and to attest. And we'll talk about that in more detail shortly.

OK, so that is slide seven. So moving on to slide eight. So here we see a screenshot of the CMS EHR Incentive Programs website and you'll see on the left side of the slide the different tabs that you can click on the website which will give you more information about different incentive program topics. The Registration tab is the third tab down from the top. So that's, again, where you would click to initiate the registration process. So that is slide eight.

Slide nine. The registration link and registration user guides, these are really important tools. So at our CMS EHR Incentive Program website there are, on our Registration tab, user guides for eligible professionals, a user guide for registration both for the Medicare EHR Incentive Program and there's one for the Medicaid EHR Incentive Program also for eligible professionals.

So keep in mind actually as we're walking through these slides, especially as you are seeing the screenshots for the CMS Registration and Attestation system, that our user guides also have those screenshots. And those user guides will be very handy tools for whenever you actually register.

There's also a video – a webinar/video of how to register if you're an EP for the EHR Incentive Programs. So again, very valuable information on our Registration tab at our website.

OK. So the next slide is slide 10. This is the – after you click on the Registration tab and you've gone to our registration system, here is your actual CMS registration module log in. Oh, great and you actually click on the registration from the Registration tab. There's a link on the Registration tab that says, "Register for the Medicare and/or EHR Incentive Program." So that's right above the user guides. Thank you.

So at the registration module, you'll see the registration log in screen here and here's where you're going to enter your NPPES web user ID and password to log in. Again, NPPES, that's the National Plan and Provider Enumeration System in which providers obtain their NPIs. So remember whenever you're entering this information that your username and password actually are case sensitive. And if you don't have your NPI yet or if you don't know your NPPES web user account then you will need to go to the NPPES site, or call the NPPES helpdesk to actually get that information.

You can also – you'll see based upon the links in the registration module here, the hyperlink, so you can see on the screen that you can also log into the Identity and Access Management system so that you as an EP can designate a third party to register and attest on your behalf. We'll be talking about that in more detail also shortly. OK? So that is slide 10.

Slide 11. OK. So this slide just shows the welcome screen and – with the tabs that are going to actually take you to the registration process and the attestation process, then you have a tab for looking up your status. So you will begin, of course, by choosing the Registration tab and also just want to point out there is a help link in the upper right hand corner of the screen for tips on navigating the system. Again these tabs are going to guide you through each phase of registration and attestation.

So next, slide 12. This slide shows the actions that you can undertake from the Registration tab. Of course, you can register but you can also modify your

registration which includes switching between the Medicare and the Medicaid EHR Incentive Programs or switching even between state Medicaid EHR Incentive Programs so you can modify, you can cancel your registration, you can reactivate a previously cancelled registration and you can also resubmit a registration. So, anyway, those are the steps that you can take from the registration screen here and that is slide 12.

So moving on to slide 13. So this screen, so slide 13 shows the information required for registration. It's grouped into topics. So they are the EHR Incentive Program, again that's where you select your incentive program, your personal information, and your business address and phone. So this screen will show when each topic is completed and when all topics are marked completed then you will see – then you would select the “proceed with your submission” button. So that is slide 13.

Slide 14. Your Medicare questionnaire. So here's the screen where you actually choose now between the Medicare and the Medicaid EHR Incentive Program. So in the example here you're choosing Medicare by clicking on the little radio button next to it, then you have to click on your eligible professional type and this drop down box once you select Medicare will automatically fill with the Medicare-eligible professional types. Then you will answer this question, “Do you have a certified EHR?”

So you don't have to answer this question “yes” at registration. You will have to answer it “yes” whenever you come back for attestation. And if you need help locating the EHR certification number for your EHR, then there is a hyperlink there that says, “What is an EHR certification number?” And anyway that will take you to the certified Health IT product list which is managed by the Office of the National Coordinator. And that's just the list of all the certified EHRs. So that's slide 14.

Slide 15. Your Medicaid questionnaire. So this slide shows the same screen but in this case you've selected the Medicaid EHR Incentive Program. So after you've selected Medicaid then you have to select your state. So your state – or actually territory since we do anticipate that by 2013 some territories are going to launch the EHR Incentive Programs. So, if you don't see your

state in the drop down box then chances are it's because your state hasn't launched yet. But right now, for example, you should see about 44 states in the drop down box. Then you would select your Medicaid-eligible professional type and in the example here you've selected, actually, "yes" to the question, "Do you have a certified EHR?" which will prompt then to fill in that EHR certification number, which again it's still actually optional at registration. OK. That's slide 15.

Slide 16. Personal Information. So here's a screen where you go – where you choose where your incentive payment is going to go and this is a really important screen. So you will select where your payment will go in the payee Tax Identification Number type you see sort of on the left side of the screen there.

As an eligible professional, you can select your individual billing EIN to receive the EHR Incentive Program. You can select your group and that's what you'll do if all your Medicare benefits are already assigned to your group in PECOS. So anyway, this is a very important screen to hold on to. So that's screen 16, slide 16.

Slide 17. Medicaid payment assignment. So Medicaid EPs can also reassign their incentive payments via the personal information screen. They can reassign them to their employer or they can also reassign them to an entity with which the EP has a valid contractual arrangement allowing that entity to bill for the eligible professional's services.

But I'll also mention this real quick, in the EHR Incentive Program's final rule, states can actually designate an entity that promotes EHR adoption and eligible professionals could actually assign their incentive payments to that entity. Right now, no states have actually done that yet. But that could be a possibility down the road since states still have that leeway. So yes, there remains an option in the future. OK. So that is slide 17.

Slide 18. So this slide shows the business address and phone number of the EP's – of the eligible professional's practice location that is identified in the NPPES, in the National Plan and Provider Enumeration System. Updates to

this screen, to the business address and phone made in the screen will not actually update your address and phone number in NPPES. So if you were to change your address information here, then you would need to go into NPPES actually, otherwise our system will still show – our NPPES system will still show the address and phone number that prepopulated here.

Also understand that for the final rule, CMS is going to post the business name, the business address, and the business phone number of Medicare-eligible professionals who receive incentives. We're going to post – we are posting those to our website. States are required to do the same thing for Medicaid-eligible professionals. But again, Medicare is posting identifying information about Medicare providers who will receive an incentive. That is slide 18.

Slide 19. Let's do a quick time check. OK. Slide 19. OK. This just shows the registration disclaimer. So you would click on the "agree" button at the bottom of the screen just to agree that your registration is true, accurate, and complete. If you click the "disagree" button, the system is going to take you back to the registration instructions' page. Slide 19.

Slide 20. Medicare successful submission. So upon successfully submitting your Medicare registration, you're going to receive this submission receipt saying, "successful submission." Print this receipt and keep it for your records since you will not receive it by email.

So again you need to print this out once you have successfully registered. If your registration submission fails, you will then also receive a failed submission receipt and on that failed submission receipt, you're going to find instructions for essentially what you need to do to revise your registration, contact information or whatever so that you know to revise your registration and make it successful. OK. So that again is slide 20.

Slide 21. Medicaid successful submission. For successful Medicaid registration as shown on this site, your registration information is going to be sent to the state Medicaid agency. This screen is just confirming that your registration was successful. And, like with the Medicare registration, you

should also print this receipt for your records. So again, it's not going to be emailed to you, you need to print this for your records.

I'll just mention: each night after people have successfully registered for Medicaid through the CMS R&A system, CMS sends all successful Medicaid EHR Incentive Program registrations to the appropriate state Medicaid agency. So that happens automatically on our end. And then what you're going to do after successfully registering for Medicaid, you're going to wait about 24 hours before you can proceed to your state's Medicaid EHR Incentive Program, at which point you're going to verify eligibility information and you're going to be able to proceed with attestation.

Just remember, registration for Medicaid EPs occurs at the CMS website, whereas attestation and eligibility verification occurs at the state EHR Incentive Program website. That's just for Medicaid EPs. OK. So that's 21.

Slide 22. This gives a preview of the Status tab. The Status tab just shows whether or not you have an active incentive program registration, it shows when your registration was successfully submitted, your personal and business information and you can see from the tabs in the middle of the page that you can also do a status check not just on registration but on attestation and payment information as well. That is slide 22.

Slide 23 addresses how an EP, as we call an eligible professional, switches between the Medicare and Medicaid EHR Incentive Programs in the registration system. So after an EP has received their first incentive payment, they can only actually switch once between Medicare and Medicaid prior to 2015. So keep that in mind. Prior to actually being locked for payment, prior to attesting for payment, you can switch back and forth. I don't know why you'd want to, but you can switch back and forth between the programs. But after you've been paid once, you can only switch one more time and that is prior to 2015 between Medicare and Medicaid. OK. That's slide 23.

Slide 24. This just compares the notable differences between the Medicare and Medicaid EHR Incentive Programs. Some of these we've already touched on, such as the maximum incentive payment for EPs is a little higher under

Medicaid. You can participate for six years and earn – receive an incentive totaling approximately \$63,750, whereas it's a maximum incentive of \$44,000 under the Medicare EHR Incentive Program with a 10 percent bonus for the health professional – for physicians – EPs in health professional shortage areas.

Some of the other differences – for every year under the Medicare EHR Incentive Program, you have to demonstrate meaningful use. Under the Medicaid EHR Incentive Program during your first year of participation, you can receive an incentive just for having adopted, implemented, or upgraded. So essentially just for having acquired certified EHR technology you can receive an incentive. But then through years two through six under Medicaid you have to demonstrate meaningful use. Also, the Medicare EHR Incentive Program ends in 2016, the Medicaid one is going to run through 2021, so anyway, I'll let you read that – the rest of that for your own reference.

Slide 25. Reassigning payments. This shows that Medicare EPs can reassign their incentive payments to groups they're associated with in PECOS. A Medicare EP will only see groups they're associated within PECOS in the drop-down list on the screen where it says, "group payee." That is slide 25.

Slide 26. Medicare attestation. This just shows the tab for Attestation that a Medicare EP would proceed to after completing registration. And as we said earlier, a Medicaid EP will actually then go to their state Medicaid agency's EHR Incentive Program portal to complete attestation. That's slide 26. OK.

Slide 27. So then moving on to Medicare attestation, slide 27 here shows the Medicare attestation instructions, and of course, as you can see, here the attestation actions you can take are: you can attest, you can modify attestation and cancel, you can resubmit, you can reactivate, you can also view. In order to begin attestation, you again already have to have an active registration status so you have to register, obviously, before you proceed with attestation. So that is slide 27.

Slide 28. Slide 28 shows that you have to complete the list of topics in order to complete your attestation, the list of topics identified here. As you complete

each item, the topic will change from “pending” to “completed.” And again, it’s going to show the attestation components that we’re going to discuss in detail, the Meaningful Use Core Measures, the Menu Measures, Clinical Quality Measures, and so on. So in order to complete your attestation you have to complete all those topics and then you would select “start attestation” to begin. That is slide 28.

Slide 29. So on the attestation information page you’re going to enter the EHR certification number. As we mentioned previously that we’re – actually I don’t think we mentioned it previously. That number is 15 characters long, it’s an alphanumeric number. It is case sensitive also. Be sure whenever you’re entering that number that you check for any typos, don’t confuse “0” and “O” or “I” and “1” or anything like that.

And also at this point in attestation you do have to enter your certified EHR – your EHR certification number. It’s optional in registration, but when you’re attesting you do have to enter it here. And again, if you need help locating it you can go to the Certified Health IT product list, a.k.a. CHPL. And also shown on the screen, you will also enter your EHR reporting period, which under stage one for first year Medicare-eligible professionals it is 90 days long. So you would enter any EHR reporting period that is 90 days. So that’s slide 29.

Slide 30. We’re already moving now to Meaningful Use Core Measures. So slide 30 again the – yes, the core measures of which there are 15. And some of the measures are going to ask you to indicate whether data was extracted from all patient records or from patient records maintained just using certified EHR technology. So at the EP’s discretion, the numerators and denominators of certain measures can be calculated using only the patient records maintained in the certified HER, or the EP can calculate the numerators and denominators of measures using all the patient records. So the EP is going to indicate the method they’re going to use in their calculations here. OK. So that is slide 30.

Slide 31 shows that EPs can be excluded from meeting an objective if they meet the requirements of an exclusion. So if the EP can’t meet the specific requirement, then the EP can answer – excuse me, if the EP can’t meet the

specific exclusion requirements, then the EP can't answer "yes" to the exclusion question here. Also, if no exclusion is indicated, then the EP has to report on that measure.

So you see here, the EP can be excluded from meeting the electronic prescriptions objective in this case if the eligible professional would write fewer than 100 prescriptions during the EHR reporting period. So again, if you write 100 or more prescriptions during the EHR reporting period, then you can't actually be excluded from this objective. OK. That is slide 31.

Slide 32 shows a measure, in this case the measure is, implement one clinical decision support rule. This is one of those measures that only requires a "yes" or "no" answer. There are no numerators or denominators. Objectives like these have to be recorded. There are no exclusions for these measures. You just report "yes" or "no" that you've done something. OK. That is slide 32.

Slide 33. This just shows that you have to enter a numerator and denominator for this measure and in this case the measure is more than 50 percent of all unique patients seen by the eligible professional, or EP, have demographic info recorded. The numerator and denominator have to be positive and whole numbers and, if you notice, there is no exclusion for this particular measure. So just to sort of give you a survey of the different kinds of measures, some have numerators and denominators, some have "yes" and "no," some you can be excluded from, some you can't. That is slide 33.

Slide 34. So this shows that, once you've finished reporting on the 15 core measures, you'll be presented with the Menu Measure questionnaire. So out of the 10 Menu Measures, you have to select and report on five, including at least one public health measure. If you can only meet one of the two public health measures, then you have to report the one that you meet. And you'll have to select four other Meaningful Use Menu Measures.

So if you meet the exclusion criteria for both public health measures, then you still have to select a public health measure and attest that you meet the exclusion. Also note that, as you can see here, you can log out of the attestation process at any point and you can continue where you left off at a

later time. All the information that you've entered up at this point actually will be saved. So that's something to know, since this is a multiple step process in which you're having to obtain a lot of information in order to successfully attest. OK. That is slide 34.

Slide 35. This shows the two public health measures. And, as I said a moment ago, you have to submit at least one public health measure from the Meaningful Use Menu Measure set, even if it's an exclusion. So OK, that is slide 35.

Slide 36. Slide 36 demonstrates what the public health measure that you selected for attestation will look like. Again you have to attest to at least one of two even if you're attesting to meeting the exclusion. So again just another screenshot showing public health – the public health Menu Measures. That is slide 36.

Slide 37. This shows a Menu Measure where the EP has filled in that they don't meet the exclusion, in this case based on writing fewer than 100 prescriptions during the EHR reporting period. So for this objective, they would answer "yes" to verify that they have enabled the drug formulary check functionality and they have access to at least one drug formulary for the EHR reporting period. Another – just a good example of a Menu Measure and what you have to do to complete it. That's slide 37.

Slide 38. This is an example of a Menu Measure that requires the EP to select whether the data for the measure was extracted from all patient records or only from the patient records that are maintained using certified EHR technology. That is slide 38.

Slide 39. This shows an example of a Meaningful Use Measure that requires the EP who has indicated that they don't meet the exclusion ... it requires the EP then to complete the numerator and the denominator for this measure. So that is slide 39.

Slide 40. OK. So this is where we're going to move into the Core Clinical Quality Measures. So EPs have to report Clinical Quality Measures directly

from their certified EHR technology. An EP has to report on three core CQMs or three alternate core CQMs and then three additional CQMs. So an EP has to report on a minimum of six CQMs and, actually, a maximum of nine. So if the denominator value for all three of the core CQMs is equal to zero, then the EP has to report zero denominator for those, you know, as reported for those core measures. And then they have to also report on the three alternate core measures.

And so also if you'll notice, versus what we were looking at in the Core and Menu Meaningful Measures, here you're going to see the denominator and numerator fields are actually swapped. So you're entering the numerator – the denominator is entered in this case before the numerator for the Clinical Quality Measures. And that's the way the system was built. OK. That is slide 40.

Slide 41. This just shows an example of a CQM and the denominator and numerator fields for the measure. And this one actually shows the numerator is 101 and the denominator is 100. The numerator should not be larger than the denominator. So I believe you would actually get an error if that were to occur. OK. So that is slide 41. Again, no numerator is larger than a denominator.

Slide 42. This is again just another example of a CQM. In this case the denominator is greater than the numerator. The denominator is 101 and the numerator of 100 that is acceptable. That is slide 42.

Slide 43. So you see with this slide that in addition to the numerator and denominator, we have here an exclusion field, too. And the exclusion field reflects the patient population that doesn't meet the criteria of the measure. So in the example that I can think of or in the example that I was reading about, so a CQM reporting patients treated – wait, so for example, for a CQM reporting patients treated with aspirin as a preventive treatment for heart attack, diabetic patients who would be allergic to aspirin would actually be excluded from this measure. So that's just an example of a population that would be excluded from a CQM measure. That's slide 43.

Slide 44. So if you entered zeroes for any of the denominators for your core CQMs then you're going to be presented with the alternate CQM screen and this screen will prompt you with the number of alternate core QMs you'd have to select. This screen would pop up again if you've entered zeroes for the core CQM denominators. That's slide 44.

Slide 45. So this shows that you have to select, in addition to the three core CQMs or possibly and the three alternate core CQMs, you also have to select an additional three CQMs from this list. It's actually a list of 44 measures and this screen just gives you a preview of really the first eight, but again, you would have to select three additional from the list of 44. That is slide 45.

Slide 46. So for the three additional CQMs that you selected, you're going to be prompted to enter a denominator, a numerator, and exclusion, if applicable, for each additional CQM. So that is slide 46.

Slide 47. So when you have finished, then, with the CQMs, you'll find yourself back at the topics for this attestation page. So after you've completed everything, it should show "completed" next to each of the topics that are listed there below. Once it shows "completed" next to the topic, then you can proceed with the attestation. You can hit that button that says proceed with attestation. OK. That is slide 47.

Slide 48. So this shows the Meaningful Use Core Measure, the Meaningful Use Menu Measure and the CQM links to what you've entered. You can select any of the links if you want to review or revise your entries for the CQMs or for the Core or Menu Meaningful Use Measures. You'll navigate back to the first page of the first measures for whatever list that you select.

So it's important to note here that this is the last chance you're actually going to have to review and edit the information that you've entered before you actually proceed with submitting the attestation.

So it's also important to remember to check your data entry for errors at this point as well. So the system isn't going to alert EPs about errors prior to

official submission of attestation, so you just have to be careful. That is slide 48.

Slide, let's see, 49. OK. So when you select a measure to edit, then you're going to have a chance again to change your numerator and denominator and any of the other information that you can put in for the CQM. So that is essentially what slide 49 is showing.

And moving on to slide 50. Edit measures, slide 50. You can edit the measures by category. In this case, the category is meaningful use core measures. So you would click "edit" next to the Core Meaningful Measure that you want to edit. That's slide 50.

Slide 51. So here is where you're going to check the box next to each statement to attest to the validity of the statement, then you would click on agree to complete your attestation. So this is the attestation statement screen. And if you choose "disagree," you're actually going to be taken back to your homepage and your attestation won't be submitted. But all of the information that you've entered will continue to be saved. OK. That is slide 51.

Slide 52. OK. This is the attestation disclaimer screen. So you, again, just read the disclaimer and click on the "agree" button to continue with your attestation or "disagree" if you want to stop the process.

Slide 53. This is your attestation submission receipt, again, verifying that you've completed and submitted your attestation. So print this receipt and save it since, again, similar to the registration receipt, you're not actually going to receive an email confirmation from CMS. So click on "Summary of Measures" down below if you want to see the summary and the details of the Core Menu Measures and the CQMs. And if you successfully attested your attestation, it's going to read "accepted."

So at this point the attestation is locked and it can't be edited and payments are actually scheduled to begin, it's usually about four to eight weeks after successful attestation, and of course after you've – assuming you've successfully met the Part B Medicare allowed billing required or claims

threshold of allowed charges .Providers attesting by the 15<sup>th</sup> of the month will receive an incentive payment typically approximately by the middle of the next month. OK. That is slide 53. Excuse me, sorry about that everybody.

OK. Slide 54. This is a submission receipt for a rejected attestation. So you see here the slide is telling you on the right side you did not meet one or more of the minimum standards. You can select review results to view your entries and then select print receipt to print this page. Again this is an example of a rejected attestation. So you have not successfully attested for the incentive program, the Medicare EHR Incentive Program.

For slide 55, here this is the screenshot of the summary of the Meaningful Use Measures again for a rejected attestation, and it actually shows you next to – if you look across the screen, it shows you which measures have been rejected, which Meaningful Use Measures in this case have not been accepted.

So moving on now to slide 56. So this list is what you have to do if your attestation was rejected, so it's something handy to keep around. So you're going to want to, first of all, reassess or modify your practice so that you can meet the measures, you know, if you didn't meet them. You will want to resubmit your documentation information again or resubmit new information, or just to review your documentation if you found an error you can correct and then resubmit it, or you can submit for a different reporting period during the first payment year to successfully demonstrate Meaningful Use Measures. That's an option as well. So that is slide 56.

Slide 57. OK. So now in this section of the presentation we're actually moving on to the third party users working on behalf of eligible professionals in the CMS Registration and Attestation system, so really working on behalf of Medicare-eligible professionals. Third party users would need to create an identification and authentication web user account. So we have this system. Again the identification and authentication, we're going to call the I&A system web user account.

So how to go about doing that, creating that account is described on this log in screen. So under "eligible professionals," you'll see that "create a log in" link.

It's also important to note here that states don't necessarily offer the same functionality with third party user attestation on behalf of the Medicaid EP. So you have to check with your state to see if they actually offer that functionality, many of them do not. The instructions for navigating the I&A system [are] found in the Medicare EP Registration and Attestation user guide. OK. That is slide 57.

Slide 58. This slide shows the security check screen. You just have to answer two very simple questions in order to get into the I&A system. And there's also the contact number for the helpdesk there at the bottom of the screen.

Slide 59. So here you would actually go – now that you're in the I&A system, you actually create a user ID and password and you have to also create some secret questions and answers to some secret questions. So once you've successfully created this user ID and you've, you know, made up the secret question and answer combination, then they will remain tied to your record and you actually cannot change them. So just try to remember your secret answer to your question because, again, those aren't changing. That is slide 59.

Slide 60. Again this just shows where you're going to enter your user profile information. OK. So your personal information.

Slide 61. So this is where you would input your employer's EIN, the legal business address, mailing address. OK.

Slide 62. Get a little time check. OK. Slide 62. So this shows your current access for your requests. So in this example there are – or actually none on the screen but if you're working with some EPs you'd be able to see the list if you've been given, if you've requested access for them and they've given you access now. They've verified that you are going to be acting on their behalf as a third party user. OK. That is slide 62.

Slide 63 now. So here is where you're going to choose – that you – here's where you're going to choose that you are requesting to act on behalf of an individual provider, so some issues previously with third party folks not

choosing that bottom category, we've seen some issues around that, so be sure that that's the one that you choose. The radio button says you are requesting to act on behalf of an individual provider. So a proxy user may now register and attest, I believe we're up to 1,000 eligible professionals. OK. So that's also gone up, I guess in the last year some time. OK. That is slide 63.

Slide 64. OK. So here is where, as a proxy user, you would choose the Medicare EHR Incentive Program and input the individual provider's NPI to search for the eligible professional for whom you want to serve as the proxy. Here's where we're going to start identifying them, the person who you're actually working on their behalf to attest for their incentive. That's slide 64.

Slide 65. So this is where you'd actually choose the individual provider that again you want to be a third party user for. So you can choose your EPs one at a time, or there is, you know, a group of them here, you can select all of them, they're all on the screen, you know, again they've all come up based on the NPIs that you recently inputted. So the EP, or EPs if you're going to act on behalf of more than one EP, would actually now have to approve your request in the I&A system. So before you can act as their proxy, the EP will actually have to go in.

Now this is important to remember: The EP is not actually going to receive an email from the I&A system saying, you know, someone's, say, the office manager is requesting to access the Registration and Attestation system on your behalf. So you're going to have to notify, as a third party user, the eligible professional that they need to go into the system and, again, grant you access. So you'll need to contact the EP and tell them to go into the system and to approve you to act on their behalf. That is slide 65.

Slide 66. So this is the path to payment checklist. So you'll need to make sure as an EP that you're eligible for an incentive and this kind of gives you some of the hard bullets that you need to check off to be sure that you can actually qualify for an incentive. There is an eligibility "wizard," actually, on the CMS EHR Incentive Program website, and it can help you determine which program you're eligible for. You should register, I think as we've – I think I indicated before that you should really register as soon as possible, and

remember also that you can register even before you've acquired certified EHR. So something else to remember.

Then of course you will just go to the certified Health IT product list and find your certified EHR, your EHR certification number once you're actually ready to attest. (They don't need it for registration, they need it for attestation.) Slide 66.

Slide 67. This is just a list of helpful resources. Again, the best and the most up to date, most comprehensive resource is the CMS EHR Incentive Programs website. This, as we've already indicated several times, not only does this contain the registration link for the CMS R&A system for the incentive programs, it has the registration user guides for Medicare EPs, the registration user guide for a Medicaid EP, it has an attestation guide, it has the webinar on registration, So it links the final rule.

So many, many very useful resources and then you also see the link for the website of the Office of the National Coordinator for Health IT at the bottom of the screen here. And that is slide 67.

Slide 68. So this contains – again, it's labeled “troubleshooting,” that contains the contact information for our EHR information helpdesk. This is an important number to have handy if you have questions or issues or other concerns with registration or attestation or anything we've covered here.

We also obviously have some other helpdesks. We were talking about NPPES, the National Plan and Provider Enumeration System. We have the helpdesk number for PECOS, the Provider Enrollment, Chain, and Ownership System. And, again, the Identification and Authentication System helpdesk number. So plenty of helpdesks there.

And then, I guess it brings us to the end of our slide deck, the Q&A session then I guess will be the next step.

Diane Maupai: Thank you, John.

John Allison: All right. Excellent. Sure.

Diane Maupai: Thank you for your exhaustive run through of the registration and attestation, nice job. Thank you very much.

John Allison: Thank you.

## **Polling**

Diane Maupai: At this time, we're going to pause for a few minutes so we can complete some keypad polling so that CMS has an accurate count of the number of people listening on our call today. There may be moments of silence while we tabulate the results. Holley, we're ready to start polling.

Operator: CMS greatly appreciates that many of you minimize the government's teleconference expense by listening to these calls together in your office using only one line. Today, we would like to obtain an estimate of the number of participants in attendance that are documenting how many members of the provider community are receiving this valuable information.

At this time, please use your telephone keypad and enter the number of participants that are currently listening in. If you are the only person in the room, enter one. If there are between two and eight of you listening in, enter the corresponding number between two and eight. If there are nine or more of you in the room, enter nine.

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

And please continue to hold while we complete the polling. Again, please continue to hold while we tabulate the votes.

## **Announcements and Reminders**

Diane Maupai: While we're tabulating, I'd like to take a minute to introduce two CMS experts who've joined us to answer questions. The first is Rob Anthony. He's a health insurance specialist in the Office of E-Health Standards and Services;

and Patrice Holtz, a nurse consultant in the Office of Clinical Standards and Quality.

And let me take this time to remind everyone that this call is being recorded and transcribed. Before asking your question, please state your name and the name of your organization. In an effort to get to as many questions as possible, please limit your questions to just one. If you'd like to ask a follow-up or have more than one question, please press star one to go back to the queue and we'll address those additional questions as time permits. Holley, when you're ready, we're ready to take our first question.

## **Question and Answer Session**

Operator: To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and to pick up your handset before asking your question to ensure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference. Please hold while we compile the Q&A roster.

And your first question comes from the line of Jennifer Montgomery.

Jennifer Montgomery: Hi. This is Jennifer Montgomery from Beth Israel Medical Center Continuum Healthcare. And I've been in the process of doing the attestation and in doing so I've noticed that the denominators and the numerators switch at the quality measure core screen and I'm not sure that you guys are aware of it, but that, to me, potentially keying-wise can be a big problem. I'm also having horrible problems with the web and getting kicked out.

Robert Anthony: We actually are aware of this and we usually draw attention to it during the presentation that, in fact, they're switched. The reason that they're switched is because, the way that the Clinical Quality Measures are e-specified, that's the order in which they are done. But it's a good point and it's something that people should definitely be aware of that when you are doing Meaningful Use Measures the numerator comes before the denominator. When you're inputting clinical quality measures, the denominator will come before the

numerator and, yes, if you're not paying attention, as you said, it's very easy to mix those up.

Jennifer Montgomery: OK. Thanks.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Tara Landano.

Tara Landano: Hi. My name is Tara Landano. I'm calling from Victory Internal Medicine. I was trying to find out during the registration – we have a couple of nurse practitioners that work in our facility, and the COO had asked me to register the nurse practitioners on the website. But when I used the drop down, I only have options for doctor, chiropractor, or doctor of podiatry. How do I go about registering a nurse practitioner?

John Allison: OK. Nurse practitioners are actually only eligible under the Medicaid EHR Incentive Program. So it looks like you have initiated a Medicare registration.

Tara Landano: Yes.

John Allison: Right. And then you're not going to see the nurse practitioners in the drop down box because they're not eligible under the Medicare EHR Incentive Program. You would have to register under the Medicaid program for the nurse practitioners.

Tara Landano: OK. Thank you so much.

John Allison: Sure.

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

Cathy Grech: Hi. This is Cathy Grech from Consultants in Cardiology. My question is, first of all, I was not able to get into the PowerPoint slide, I wasn't able to see it, but my question is, did I understand you [to] say that once you submit your register – I'm sorry, your attestation, if you do not pass, you can resubmit for later than 90 days?

Robert Anthony: Do you mean if your attestation has been rejected, can you resubmit for another period? If that's the case, then yes. If you have an attestation that you submit and it's rejected, it is possible to resubmit that attestation for a different 90-day period within the same payment year. It doesn't have to be a completely different 90-day period, that 90-day period can overlap.

So for example, if you first input it for January 1<sup>st</sup> through March 31<sup>st</sup>, you could then input data for January 2<sup>nd</sup> through April 1<sup>st</sup>. And that would satisfy as well. So it is possible to resubmit for a new period.

Cathy Grech: OK. Thank you very much.

Operator: And your next question comes from the line of Julie Gee.

Julie Gee: Hi. This is Julie Gee with Willow Bend Family Medicine. We've completed our initial attestation. I've got all the paperwork. I have two physicians in my office. However, I understand that we will get no kind of – any kind of notification whether or not – what the statuses [were] or where our physicians are in line or whatever. How do we find out?

I mean, I keep checking on your website for those physicians – EPs that had them-received-their initial payment, how – or how long does the process take before we should see some type of payment?

Robert Anthony: Assuming that the providers have met their thresholds for – are we talking on the Medicare side? I should probably...

Julie Gee: Medicare. Yes. We're not Medicaid providers, we are Medicare, and I completed their attestation and I was completing it for 2010 – or excuse me, 2011, and I've only – I came on towards the end of last year so we didn't complete it initially on one provider so we waited for the new year, and I submitted that for the 90 days in March, right into March, and here we are in April, and when it went through, it says, "successful," and when I go to check the status of the physician's payment, it just says, "pending," and I was going to pull it up now, it says, "pending payment."

Robert Anthony: No, I'm going to suggest actually because yours is – sounds like a specialized problem. I'm going to suggest that you call our EHR Information Center.

Julie Gee: OK.

Robert Anthony: Because somebody should probably look specifically into your situation. That is on the troubleshooting slide, it's slide 68. You can see that number at 888-734-6433, because it sounds like you may be in a situation where we held the attestation to meet claims threshold so we were waiting for claims processing. But they'll be able to tell you exactly where the payment is in the process.

Julie Gee: Very good. OK. Thank you.

Robert Anthony: Sure.

Operator: Your next question comes from the line of Geoffrey Wiedeman, Jr.

Geoffrey Wiedeman, Jr.: Yes. Hi, this is Geoff Wiedeman, Hand Surgery Associates in Sacramento. We have five hand surgeons here. I believe that we're all appropriately signed up and adequately registered in the PECOS system, but I'm not absolutely positive that we're squared away with respect to our practice.

What is the best strategy for ensuring that everything is on the up and up and properly registered? Can we go ahead and register and then sign our attestation period to be a period later in the future, say starting in six weeks or eight weeks, or should we use the "wizard" that you keep talking about?

Robert Anthony: Yes, you know, you can actually register at any point. You don't have to indicate when the attestation will be. Registration doesn't commit you to attesting at a certain point or at all, really.

So my advice is to register now for the program. You'll find out pretty much right away whether you have any kind of issues with PECOS that would include whether you have the correct association for your EPs to the practice. And then if you do, then you can work with the PECOS helpdesk, and again,

that number is on that troubleshooting slide, and they will – they will help you resolve what you need to resolve in order to make sure that your registration is successful for this program. The short answer is, that yes, you can absolutely register now to attest in the future.

Diane Maupai: Thank you, Rob.

Operator: And your next question comes from the line of Debra Bradley.

Debra Bradley: Hi. This is Debra Bradley from Kaiser Permanente. We are a Medicare Advantage organization and register our EPs and HPMS through an Excel template. I understand that Excel template is going to be different in 2012 versus 2011. Do you guys know the difference? What else is additionally required?

Robert Anthony: You know, off the top of my head, I couldn't tell you what the spec changes are going to be. I can tell you that our folks on the MAO, EHR incentive side will send out notification to everybody to let you know what the difference will be.

Debra Bradley: OK. Thanks.

Robert Anthony: That was Rob by the way.

Diane Maupai: Thank you. Thanks, Rob.

Operator: And your next question comes from the line of Susan Campbell.

Susan Campbell: Susan Campbell from Brockton Neighborhood Health Center in Massachusetts. My question is on, if an EP has already attested during one calendar year, and changes facilities during that same calendar year, can they sign up right away with their new organization, or do they need to wait for the next calendar year? That's question – part A of that question.

Robert Anthony: The key to understanding this is really understanding that payments are not made to organizations. They're made to each individual eligible professional. So if an eligible professional has already received an incentive payment for

the year, they cannot receive another incentive payment. They can only receive one payment a year.

So if you got a payment in 2011 for working at one practice, and then in 2012, you moved to a separate practice, a new practice altogether, you would have to – I'm sorry, if you move later in the year to another practice, you would have to wait until the next year, 2012, to get another payment.

Susan Campbell: That's – I did anticipate that as an answer, but my question is more – can they sign up with the new practice right away when they join the new practice, or does sign up need to be deferred to the next calendar year?

Robert Anthony: So once you're registered in the system, you are registered. You can go back and change for the next year, where the designation for the payment would go, but otherwise, that information is already drawn from our PECOS and it's already there and available. There's nothing that prevents you after you have attested and received payment from going back and changing that information though.

Susan Campbell: And if you have attested but not yet received payment and you move to your new facility, then what? The old facility gets the payment even though you've already changed?

Robert Anthony: However, the EP designated for their incentive payment to be paid, or whoever they designated that to, that's who's going to receive the payment.

Susan Campbell: At the time they attest it, whoever was listed has the...

Robert Anthony: When you attest, you have to indicate who is receiving the payment.

Susan Campbell: Yes.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Barbara Frost.

Barbara Frost: Barbara Frost, I'm with Central Indiana Orthopedics, and my question stems from the discussion on hospital-based. Could you elaborate on that a little bit? We're primarily a surgical practice, so many of our Part B charges would be tied to services provided at Place of Service 21. So I want to make sure I understand that correctly.

Robert Anthony: The definition for a hospital-based professional is somebody who provides 90 percent or more of their Part B charges – their covered professional charges in either in-patient or emergency department, and, as you know, in-patient is POS 21 and POS 23. I know that there are a number of people who do work in surgery centers like yours, where the majority of their provider's services are provided in POS 21, so they would not be eligible to participate in the program.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Bryan Wilfong.

Bryan Wilfong: In terms of Medicaid claims, if a nurse practitioner provides a service, but the encounter is billed under a physician, does the encounter attribute to the nurse practitioner or to the physician?

John Allison: It can actually be accounted towards the 30 percent Medicaid patient volume of both. So the rendering provider you're saying is the nurse practitioner, the billing provider is the physician, correct?

Bryan Wilfong: Correct.

John Allison: That's the example you're giving, no? That encounter could actually be attributed to both the nurse practitioner and the physician.

Bryan Wilfong: Thank you.

John Allison: Sure.

Diane Maupai: Thanks, John.

Operator: And your next question comes from the line of Felicia Wheeler.

Felicia Wheeler: Yes. Will Virginia ever allow a third party proxy for the Medicaid?

John Allison: Well, Virginia, you know, they're getting around to launching and they have told us they intend to launch in July, but I don't know. We haven't had that discussion in our central office with Virginia whether or not they're allowing a third party proxy for attestation under Medicaid. So that would be something that you should actually follow up with the state on. And again, you could actually find the state's website information, which would give you more of their contact information at the CMS EHR incentive program website on the state Medicaid information page.

Felicia Wheeler: OK. Thank you.

John Allison: OK. Sure.

Diane Maupai: Thanks, John.

Operator: And your next question comes from the line of Wanda Carter.

Wanda Carter: Wanda Carter from Northwest Louisiana Nephrology. We are currently in the process of registering and really trying to decide if we meet the 50 percent threshold. Can somebody give me the – I guess layman's terms for the formulary to figure the threshold?

Robert Anthony: Well it's not necessarily much of a formulary. It basically comes down to if the EP practices in locations – they have patient encounters – 50 percent or more of their patient encounters in locations with certified EHR technology, then they can participate and they can base their denominators on just those locations with certified EHR.

So as long as – no matter what combination it is, whether it is two practices where they're doing 50 percent in one and 50 percent in the other, or whether it's eight practices and they combined five of them to reach their 50 percent threshold. They just have to have 50 percent or more of their patient encounters in locations with certified EHR.

Wanda Carter: OK. So if we take our total claims submitted, I was told by the helpdesk that we could subtract the Place of Service 21 and 23, and then they – our office is the only one with EHR, we should be able to use that?

Robert Anthony: Yes, essentially when you're looking for an EP's encounters, whatever they do in Place of Service 21 and Place of Service 23, doesn't count toward their meaningful use because that, of course, is captured under the eligible hospital or the CAH's attestation. So you would take those out of the equation and then you would just look at those other services and see whether you do 50 percent of those in a location equipped with certified EHR.

Wanda Carter: OK. And are these unique patients or total charges?

Robert Anthony: It's actually patient encounters.

Wanda Carter: Patient encounters. But are they unique?

Robert Anthony: No, it's total patient encounters.

Wanda Carter: OK. That's what I needed to know.

Robert Anthony: Yes, ma'am.

Wanda Carter: Thank you.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Lori Johnson.

Lori Johnson: Hi. I have a couple of questions. So if a provider joins your practice in 2012, and in 2011, they had successfully submitted their 90-day attestation for the Medicare program. And then they come to you in 2012 mid year, can you attest for them in 2012 even though you would not have a full year of data from your EHR?

Robert Anthony: You can – there are a couple of ways of doing this actually, and it's sort of depends on what your situation is. If a provider transfers in 2012 from another

practice, let's say six months into the year from this other practice. If for the six months prior to this year they were using certified EHR in that other practice...

Lori Johnson: Right.

Robert Anthony: ... and they need to get data from that other practice and combine it, you basically add together the numerators and denominators with the six months of data from your practice.

Lori Johnson: OK.

Robert Anthony: If they did not do any type of – they – let's say they attested in 2011 with the practice, and then they took January through June off.

Lori Johnson: Right.

Robert Anthony: And then they started with your practice in July, well in that case, it is possible still to do that and attest with just that six months information, but you still need to be able to meet meaningful use for that entire year. So where it becomes a little bit more complicated is let's say they moved in the first six months of the year to a practice that didn't have certified EHR, and then they moved to your practice, well you still have to figure those other folks into the denominator of it.

We don't specify – although we specify the reporting period as a full calendar year in your second year of participation. We don't necessarily say that you have to have been using an EHR, certified EHR everyday of that year. It's hitting those thresholds over that entire reporting period that you're required to do.

Lori Johnson: So you would just have to start your report period from – it would – your report period would just have to include the whole calendar year.

Robert Anthony: That is correct.

Lori Johnson: And then if – say they were at a practice before that did not use an EHR, how would you include those patients that – their records weren't maintained

electronically. And say they came to your practice and you do use an EHR, are you saying you'd have to try to figure data that was not electronically stored from the other practice?

Robert Anthony: Well it depends.

Lori Johnson: OK.

Robert Anthony: If you meet the 50 percent threshold, then those technically can be excluded.

Lori Johnson: OK. So if you meet 50 percent, with the EHR. And then as far as, you know, I had a little bit of trouble getting data from prior organizations when our providers have come to the practice. They want to know what they need to provide. Just numerator and denominator? And is that going to be sufficient for us to maintain as an audit trail, because for our providers, we maintain, encounter in patient specific data in addition to the numerator and denominator for audit purposes, but information coming from another organization's EHR, I don't think they'd provide patient specific data.

Robert Anthony: Right. I can't tell you what would satisfy in terms of an audit. All of the information that we have that is available regarding what you need for an audit is actually on our website and it's basically to retain records to show how you got to the calculation of your measures. As far as getting to information that you need to actually enter for attestation, it's really pretty much numerator denominator, and obviously yes/no, but presumably those are all "yesses."

So if you have something from the other practice that shows the numerator and denominator, and you can add that to your numerator and denominator, that should be sufficient for you to accurately report.

Lori Johnson: So, and then for those other things that are yes/no attestation, we could use the – the documentation that we have that our EHR is capable of doing those things, like submit immunization.

Robert Anthony: Well they're going to have to be able to say that they were able to do those things at the other practice as well.

Lori Johnson: Oh, they have to have been able to do them at both practices?

Robert Anthony: You have to have been able to meet meaningful use for everything.

Lori Johnson: Oh, OK.

Diane Maupai: All right, thank you. Thank you, Rob, and we'll move on to the next question.

Operator: OK. And your next question comes from the line of Dianne Smith.

Dianne Smith: Hi. This is (Dianne Smith) from Innis Community Health Center, and I'm here with Dr. Leon Williams and we have a question regarding assigning payments to the entity. I know that this is a provider-specific program, but is there a way to assign that payment to the entity as far as them keeping the funds, or how does that work?

Robert Anthony: So when you actually register, you'll indicate who the payee TIN is. Whatever group is associated with that particular provider within the PECOS system, it's going to come up on that list of drop down to whom you can assign payments. And that's how you would assign to a practice or an organization.

Diane Maupai: Thanks, Rob.

Dianne Smith: OK. So in other words, the doctor has that capability of assigning it to the organization, otherwise, he has to receive the whole payment himself, right? Is that correct?

Robert Anthony: Actually, you can only assign payments to organizations that you're linked to in PECOS, and most physicians, most providers are not identified as selecting – or self-selecting as far as payments for claims. So it's really going to be paid through the existing channel that we have on file at Medicare, and for the vast majority of providers, that's going to be practices or organizations that you're already affiliated with in our system.

Operator: And your next question comes from the line of Rachel Horst.

Rachel Horst: Hi. This is Rachel Horst from Ephrata Community Hospital. I had a question also regarding the payments. We do have some providers who have successfully attested for 2012 and as far as we can tell from the records that we have here, they have met the Medicare level of threshold for the Part B claim, and I have attested for some of them on their behalf by April 6th, I believe is – was the attestation date, and I do keep checking their status on the website and it does still keep saying, “payment pending.” So will that change when a payment is actually issued? Do I need to call to get a status? Because I’m pushing the eight-week marker here soon.

Robert Anthony: It will change once the payment has been issued. I would say to continue holding on that because you are just barely pushing the eight week envelope on it.

Rachel Horst: OK.

Robert Anthony: It’s also not necessarily an indication of the claims on your side because while you may have filed claims in a certain period, it doesn’t necessarily mean those claims have been processed yet.

Rachel Horst: OK.

Robert Anthony: So, it’s going to – we can only go by what we have in our system.

Rachel Horst: Correct.

Robert Anthony: So we need to take a look at the claims that are filed, so it may have actually for whatever reason, a claim may not have been processed, and don’t have time for us to do that download and check it against the payment cycle, so that in itself could push it out for another payment cycle.

Rachel Horst: OK. Great. And you did mention I was trying to write that down when you had talked about the 15th of the month, something about by the 15th of the month, and then it’ll be issued the next – the middle of the next month?

Robert Anthony: Yes, yes, we generally take a look the 15th of the month so it sort of depends exactly when the Friday falls.

Rachel Horst: OK.

Robert Anthony: And they do try to put it into the batch, if it hit that, put it into the batch for the next month, which means you would receive it depending on whether you're electronic or paper, within four weeks of that.

Rachel Horst: OK.

Robert Anthony: So that's where generally the eight weeks comes from.

Rachel Horst: OK.

Robert Anthony: But again, if you haven't particularly hit the threshold, then it can be longer than that.

Rachel Horst: OK. Understood. Thank you.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Lyman Dennis.

Lyman Dennis: Hi. This is Lyman Dennis, El Dorado Health Consulting. I've been assisting some critical access hospitals with attestation, and the biggest block is usually that they're not in PECOS, and I was – one of the speakers said something about their potentially being something on the web – on a website that you could check their PECOS status proactively, is that correct?

Robert Anthony: There is a way – there is a way to do a log in using I&A into PECOS to take a look at status. If they're not aware how to do that, I would encourage those critical access hospitals to call their – their MACs, their financial intermediaries or fiscal intermediaries, to discuss how to do it. They'll have more complete details on how to access all of that. We're really focusing on eligible professionals for this call so I don't want to go too deep down what critical access hospitals need to do but a lot of the questions they have about accessing systems and about cost reporting can be answered through their MACs.

Lyman Dennis: Thank you.

Diane Maupai: Thanks, Rob.

Operator: And your next question comes from the line of Steve Harris.

Stephen Harris: Yes, Steve Harris, Tampa General Hospital. We have done a build in our EHR software to retroactively be able to go back and capture 90 days of quality measures. And we've been able to do that very accurately, we feel, for the denominators, but for the numerators in certain cases for certain quality measures, we are not as confident that we've been able to capture the numerator portion for one or two quality measures. Do we still meet the 90-day criteria in that situation where we've captured the denominator but are less confident on one or two of the numerators?

Robert Anthony: So I can tell you that there's actually a couple of FAQs that address those through our website, and if you go to our website and look under the FAQ section and actually search under clinical quality measures, you'll be able to turn those up.

And essentially, what it comes down to is that we know that right now, all certified EHR technology isn't necessarily capturing all of that data with complete accuracy. We're certainly striving, as we move forward with meaningful use, and if any of you are familiar with some of the things we proposed for stage two, you'll see that we're driving a little bit more towards the idea of accuracy and capture and calculation of clinical quality measures.

But what providers are responsible for in stage one is capturing that information with certified EHR technology, calculating it with certified EHR technology, and submitting exactly what your certified EHR spits out in a report. So you're essentially transposing those numbers. You are not responsible at this point for the accuracy of those calculations. That's built into the EHR. You're just responsible for reporting directly from a certified EHR.

Lyman Dennis: OK, thanks.

## **Additional Information**

Diane Maupai: OK. Thank you, Rob. This is Diane. I'm sorry but that's all the time we have for today. And I'm sorry we weren't able to get to all of your questions but please be assured that we're reviewing the questions you submitted during registration and we were asked today to update our frequently asked questions, our educational products and our messaging. So we are taking that information into account.

Don't forget to join us for our next call, Wednesday, June the 27th, 2 o'clock Eastern, when CMS and the Office of the National Coordinator will present on incentive programs and certified EHR technology.

I want to point out that on the last slide of the presentation you'll find information and a URL to evaluate your experience with today's call. The evaluations are anonymous and strictly confidential. You will receive a reminder email from CMS National Provider Calls within two business days regarding that opportunity. If you've already completed the evaluation, just disregard that email. And thank you, we appreciate your feedback.

We'd like to thank everyone for participating today's call. A recording and written transcript will be posted to the National Provider Calls page, and under the calls events tab. Again, my name is Diane Maupai. It's been my pleasure serving as your moderator. I'd like to thank John Allison, Rob Anthony, and Patrice Holtz for their participation today. And have a great afternoon everyone.

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

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