

**Centers for Medicare & Medicaid Services
Stage 1 of the Medicare & Medicaid
EHR Incentive Programs for Eligible Professionals:
First in a Series
Moderator: Diane Maupai
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Operator: At this time, I would like to welcome everyone to today's National Provider Call. All lines will remain in a listen-only mode until the question-and-answer session. This call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. I will now turn the call over to Diane Maupai. Thank you, you may begin.

Announcements and Introduction

Diane Maupai: Thank you and good afternoon. This is Diane Maupai. I'm from the Provider Communications Group here at CMS in Baltimore, and I'll serve as your moderator today. I'd like to welcome you to this National Provider Call on Stage 1 of Meaningful Use for eligible professionals. National Provider Calls are part of the Medicare Learning Network.

Before we get started, I have a few announcements. Links to the slides for today's presentation were e-mailed to all registrants earlier this afternoon, about noon eastern time. These materials can also be downloaded from the National Provider Calls Web page, at www.cms.gov/npc. Again, that URL is www.cms.gov/npc. At the left side of the Web page, select National Provider Calls and Events, then select the May 30th call from the list.

This call is being recorded and transcribed. An audio recording and written transcript will be posted soon to the National Provider Calls and Events section of the MLN National Provider Calls Web page.

This call is the first in a series of six EHR calls we'll be having this summer. If you turn to slide 4, you will see the dates and times of the upcoming calls—clinical quality measures, hardship exemptions—a lot of good content, you know, broken up into some calls.

Registration is now open for our next call, which is Thursday, June 27th, and it will be on certification with the Office of the National Coordinator for Health Information Technology.

At this time, I'd like to introduce our speakers for today. They're from the Office of E-Health Standards and Services, the HIT Initiatives Group. We have Kathleen Connors de Laguna, a health insurance specialist, and Travis Broome, Team Lead for Policy and Oversight.

Kathleen will start off with an overview of the basics, including eligibility, incentives, and Meaningful Use, and Travis will cover registration, attestation, and helpful resources. Then we'll open the line for your questions. Kathleen?

Presentation

Eligibility and Overview

Kathleen Connors de Laguna: Thank you, Diane. And we're going to forward to slide number 6, and I'd like to begin by going over who's eligible to participate in the EHR Incentive Program. The overall eligibility was designed – defined in statute by Congress, and in the next few slides I'll be going over that.

One of the key points, though, that we want to make clear to providers is, providers who we define as hospital-based are not eligible to participate in the EHR Incentive Program, and we define a hospital-based provider as one that has 90 percent or more of their covered professional services in either an inpatient setting, which is Place of Service 21, or an emergency room setting, Place of Service 23, of the hospital.

Incentives also are based on an individual level, not on a practice basis, so each individual provider should be registering and attesting to Meaningful Use if they want to participate in this program. Next slide.

In this slide, we have a diagram of the total realm of who is eligible to participate. As you can see on one side, we have the – identify the Medicare-only eligible professionals, other side, Medicare-only eligible professionals – Medicaid, excuse me. And in the center, the common providers that are in both of the – eligible to participate in both programs.

So just to briefly summarize, in the Medicare-only side, doctors of optometry are able to participate and doctors of podiatry, podiatric medicine, chiropractors. And on the Medicaid-only side—that would include nurse practitioners, certified nurse midwives, physician’s assistants—specifically when working at an FQHC or Rural Health Clinic that’s led by a physician assistant, and under certain situations – under certain circumstances, optometrists can be eligible to participate under the Medicaid program as well. Physicians, doctors of medicine, doctors of osteopathy, and doctors of dental medicine or surgery are eligible to participate in both – could be eligible in both the Medicare and Medicaid incentive program. Next slide, please.

Diane Maupai: Oh – it’s on slide number 8?

Kathleen Connors de Laguna: Eight, thank you. Here we’re – I want to drill down through the Medicaid program – a little bit more information. So we mentioned on the previous slide some of the different types of eligible professionals that are eligible, but they also have other eligibility criteria. These eligible providers must either have greater than or equal to 30 percent of their patient volume as Medicaid patients, and pediatrician, that’s reduced to about 20 percent – greater than or equal to 20 percent of their overall patient volume.

For the providers that practice predominantly in a Federally Qualified Health Center or Rural Health Center we – like, they need to have greater than or equal to 30 percent of needy individuals in – within their patient volume. We define them in many ways in our regulations, that are individuals who have no cost or sliding scale for their payment, those with uncompensated – are considered to be uncompensated care, they receive medical assistance, or are under the CHIP program.

And when the Federally Qualified Health Center or Rural Health Center is the clinical location for greater than 50 percent of the eligible professional’s total encounters, we’re looking at at least 6 months in the most recent calendar year. We also require that these eligible professionals are licensed and credentialed in their States, that they have no exclusions from the Office of Inspector General, and that they’re still alive—that’s a key one—and I’ve already mentioned to

you that they cannot be considered hospital-based for the – providing the majority of their services.

Slide 9, please. On this slide, we drill down a little bit with the Medicare basics for eligible professionals. I've already mentioned the types of professionals eligible. What we also look at to determine that hospital-based status is Part B Medicare-allowed charges. So we have a certain threshold that providers need to meet overall allowed charges, and then beyond that we go into the determination – if they meet – demonstrate Meaningful Use, how to calculate their incentive payments. Again, any provider must not be a hospital-based provider and, very importantly, the provider must be enrolled in the Provider Enrollment Chain Ownership System, and those are – in a nutshell.

Medicare side, we'll go to slide 10. So you're all probably wondering, how much are those incentive payments? I'll break that out again by the two different programs. For Medicare program, the actual incentive amounts are based again, as we mentioned, on that fee-per-service allowable charges. And this year, we're in the third year of our Meaningful Use program. So, now the maximum that a provider that would register coming in this year would be eligible for up to 39,000 over the remaining 4 years of the program, and those incentives are front-loaded with up to 18,000 for the first 2 years of the program.

Incentives – if the – so, for any eligible provider that started after 2012, which would be all of you if you decide this year or later, you will be eligible for a little bit less of the total maximum that was previously available, but there's still time to participate, and we really encourage providers to participate – begin participation by 2014 so they will be eligible still for the incentive payments.

The last year that we'll be making incentive payments under the Medicare program is 2016. Providers are also eligible for an additional bonus if they practice in predominantly a health professional shortage area, and that would be an additional payment bonus in addition to the set incentive payments. And a provider is only eligible to come in once each year for an incentive payment under the program.

Slide 11. We're going down to how much are the incentives for the Medicaid provider? Medicaid has maximum incentive payments of \$63,750 over a 6-year period. The incentive payments are the same regardless of which year they start. First payment year incentive is \$21,250. The Medicaid payment doesn't require providers to participate consecutively, but they must begin by 2016 to receive incentive payments.

Medicaid providers are not eligible for an additional bonus if they practice in a health professional shortage area. And the Medicaid incentive program bonuses are – incentives, excuse me – are available through the year 2020 – 2021, and just as with the Medicare program, they're only eligible for one incentive payment per year.

Slide 12, please. In the first year for Medicare – Medicaid providers, they are required to – or receive a payment just by adopting, implementing, or upgrading certified EHR technology. Adopting is if they've acquired access to the certified EHR technology in some way that they're

legally or financially committed. By implementing, we mean that they began certify – using this technology. And upgrading could also be considered for any provider who’s demonstrated having upgraded their access to electronic health record technology, or they’re newly certified in a legally or financially committed manner.

Meaningful Use

Slide – now I’d like to go into a little bit more detail about the Meaningful Use for – Meaningful Use program, but from a very high-level perspective. So we’re going to switch – forward to slide 14. And this slide provides for you the vision for the EHR Incentive Program. It’s – really was designed to be implemented in incremental stages of functionality, with each year building upon the previous year.

So, today we’re talking about Stage 1 in – of Meaningful Use, and the focus of Stage 1 is by improving upon data capture and data sharing, collecting health information in a structured format into the electronic health record to facilitate health care decisionmaking and facilitate many other functions for providers. So we’re going to move forward to slide 15 and some of the specific requirements of Stage 1 of Meaningful Use.

The reporting period for providers in their first year of Meaningful Use is 90 days, and then subsequent – each subsequent year is a 1-year period. Providers report to demonstrate Meaningful Use through attestation – an attestation process, which we’ll be going over a little bit later, and we have identified many objectives in clinical quality measures that they must meet in order to demonstrate Meaningful Use. The reporting may be either through a yes/no format or a numerator/denominator – denominator attestation process. To meet certain objective measures, 80 percent of patients must have their records in a certified EHR technology.

Slide 16. So, Stage 1, objectives and measure reporting. As an eligible professional, you must complete 15 core objectives, and then we have menu set objectives, and a professional must complete 5 out of 10 of those menu set measures, and a total of 6 clinical quality measures.

So if you go now to slide 17, we show you an overview of the core objectives, which you can go into with more detailed information by visiting our specification measures – specification sheet found on our Web site, www.cms.gov/ehrincentiveprograms. You would click on the Meaningful Use tab on our Web site, scrolling down to the bottom, and select eligible professional, and there you’d have access to specific criteria and definitions of the numerators and denominators for each measure, as well as the exclusion criteria for these measures.

Slide 18. Some of the Meaningful Use objectives won’t be applicable to every single provider’s clinical practice. And they – we understand that not every provider will be able to meet all measures, so as I mentioned previously, we do have exclusion criteria for many of the measures. And for providers who do select those exclusion criteria, they would not count against the total deferral of five deferred measures.

In these cases, the eligible professional would be excluded from – would be – certain cases where they would be excluding from Meaningful Use, would be a dentist who might not be

performing immunizations for all their providers, or a chiropractor, for example, that might not be electronically prescribing prescriptions. So please take a look at those when you review the objective – the specification sheet for the Meaningful Use objective.

Slide 19. One thing that we've learned now that we're into the third year of our program is that many of the eligible professionals work across multiple settings. And so for those professionals that work across these multiple settings but they don't have certified electronic health record technology available with all of them, we do require that they have at least 50 percent of their total patient encounters at a location where certified EHR technology is available to them. And they would need to base all their Meaningful Use measures only on those encounters that occurred at locations where certified EHR technology is available.

Slide 20. Clinical quality measures. Eligible professionals who are seeking to demonstrate Meaningful Use are required to also report clinical quality measures to either CMS or to the States using their certified EHR technology. And they have several ways they can do this. They can submit aggregate CQM nominate – numerators and denominators and exclusion data by attestation process, or they can select to participate in the electronic reporting pilot when they're going through the attestation.

Slide 21. Now, just an overview of some of the big differences between the Medicare and the Medicaid program. Medicare is a Federal Government program implemented by the Government and operated nationally. Medicaid is – each State has – it's a voluntary program, and each State is implementing that – or choosing to implement that program differently.

Under Medicare, we will begin payment reductions in 2015 for any provider – all providers who would have been eligible to participate in the EHR Incentive Program but chose not to, or were not able to demonstrate Meaningful Use. Medicaid – under the Medicaid program, there will not be payment reduction for providers who primarily see Medicaid patients.

Under Medicare, all providers must begin in Stage 1 Meaningful Use and demonstrate Meaningful Use in their first year. Under the Medicaid program, they – providers will begin by adopt – they can either choose to adopt, implement, or upgrade their EHR technology as the option for their first year of participation in the program. Again, under Medicare the maximum incentive for providers who began prior to 2013 was \$44,000. And now starting in 2013 forward, it's a total of \$39,000 that providers are eligible for, and in addition, anyone who was eligible for the HPSA bonus, that would be on top of this.

The Medicaid program maximum incentive is \$63,750 for eligible professionals. Under Medicare, the Meaningful Use definition is common across all Medicare providers, but for Medicaid, States can adopt additional requirements for Meaningful Use if they have obtained CMS approval. Under Medicare, the last year a provider may initiate participation in the program is next year, 2014, and the last year that we will – I did already previously mention that payment adjustments will begin in 2014 for any provider that hasn't chosen to do so or is not demonstrating Meaningful Use.

Under the Medicaid program, the last year a provider may initiate participation in the program is 2016, which is also their last year to register. And now, I would like to turn it back to Diane.

Keypad Polling

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

Operator: CMS 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. 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 between 2 and 8. If there are nine or more of you in the room, enter 9. Please hold while we complete the polling.

Please continue to hold while we complete the polling.

Thank you for your participation. This concludes the polling session. I will now turn the call back over to Ms. Maupai.

Diane Maupai: Thank you, Victoria. And I'm now going to turn the call back over to Travis, who's going to discuss registration and attestation.

Presentation Continued

Registration Overview

Travis Broome: Great, thanks Diane. Now that Kathleen has convinced you that you're eligible for the program, you know, kind of, what do you do next? There are really two pieces to – between – that you would work with us, for CMS or your States after eligibility, and you do your EHR, and those are registration and attestation. So we're going to walk through how to do those things. Obviously there is that little piece of getting in the EHR in the middle there, but that's something we'll talk about on another day.

So, first thing is we've got to know what program you're in. So Kathleen went through the eligibilities between Medicare and Medicaid. It is different if you choose to participate in Medicare or Medicaid, but you always start at the same place. So you can see on slide 23, whether you want to do Medicare or Medicaid, you're always going to start at our CMS EHR Incentive Program Web site, and that is where you will do your initial registration no matter what program you're doing.

If you're doing Medicare, you're going to stay on that Web site all the way through, as we'll talk about in a little bit, and I'll show you some screenshots. If you're doing Medicaid, you will move

on to the State for which you are attesting to Medicaid in, and we have some example screenshots from a given State. Obviously, we don't have screenshots from all 50 States.

Moving on to slide 24, you can see the log-in instructions for registration. So this – again, this is something everyone will do, Medicare or Medicaid, you log in using your NPDES, which is the system that supports your National Provider ID Web user account and username and password. So this is not a unique username and password to the CMS attest – EHR attestation system, this is something you already have from when you got your National Provider ID, or your NPI.

There are two – basically two people who can log in and be a given eligible professional for NPI—the eligible professional could use their own log-in, or NPDES has the ability to designate people to act on that eligible professional—you know, the doctor, the other provider or the hospital, et cetera, et cetera—on their behalf. Those people do not use the doctor's or the hospital's log-in—or probably the doctor's, the hospital probably only has on behalf—log-in. They get their own, so it is a unique thing, but they'll be able to see when they log in all the physicians to whom they are linked in the underlying database of NPDES. And you could be linked to one doctor or you could be linked to 600 doctors. It all depends on how it's set up in the system.

Again, so you use your own user ID and password whether you are the eligible professional or whether you are acting on behalf of an eligible professional.

Once you successfully log in, you'll go to slide 25, or actually you'll go to the screen, right, on slide 25. And that gives you – call it the home screen. And there are basically three things you can do in our system if you're going the Medicare route: registration, attestation, and you can see your status. If you're going the Medicaid route, you're just going to worry about registration. This is pretty self-explanatory, so we'll keep rolling through so you can see examples of how to actually do that.

So on slide 26, you clicked on the “registration” tab and this is what registration looks like. If you look on the bottom of slide 26, you can see the information. Because you did use your NPI accounts information to log in, it will pull that information from that system for you—your name, you know, the incentive type program, you select which one you want to register—Medicare, Medicaid, national provider ID, obviously we'll pull that from the user account. And then there – in this case, on this example, there's only one tax identifier. There might be multiple tax identifiers linked to an NPI, in which case you would have to pick one. And that tax identifier comes from the – if you're doing Medicare, comes from the Medicare PECOS system or the enrollment system.

So again, that NPI would have to be linked in an outside system, in this case PECOS, to that TIN. If it's the same tax ID to which your Medicare claims go forward, you're probably fine. It will probably be there and whatnot. If you wanted – if you created a unique TIN for your EHR incentive payment—a taxpayer ID—you will probably need to link that in PECOS first in order to have that appear on our system. But when you go into the system, pretty self-explanatory, there will be options to pick from. If there – you don't like any of those options, you need to go to PECOS and get it added. If you like one of those actions, just pick and move on to slide 27.

Slide 27, some of the information we just said, so this is where you actually pick Medicare and Medicaid, you can see there in the middle of the page. And you would select what type of eligible professional you are—doctor of medicine, doctor of optometry, doctor of chiropractic—whatever eligible professional type you are. If you click Medicaid, obviously you will get a different dropdown than if you pick Medicare. As Kathleen went over, there's different eligible types for each.

And then you will have the opportunity, but not required, to put in your certification number for your EHR. So when you buy your EHR, your – whoever you bought it from, or if you built your own and got your own certified, you will get numbers, you'll – called certification numbers for the EHR product. And basically you go to a Web site and you take – maybe you only have one number, maybe you have six different products you're putting together, but you're going to put those numbers into a Web site that's known as the CHPL. The link will be kind of – later on when we get to the resources section of the presentation. And that will give you one unique CMS EHR certification number.

That number will be unique to you; it's unique to the EHR combination you're using. Be it one big piece, a complete piece you bought, or be it a dozen pieces that you bought and put together, that can go there. You will have to give us that in attestation eventually; you will always have to give it to us eventually before you can attest. You do not have to have that number to register.

OK. Slide 28 is after I register, so after slide 27, and I do all those things, it will get a successful submission, assuming it was successful. You can print it—print or save, however you prefer to do it—this particular page, because this is your submission receipt, and most importantly, it will give you a registration ID number. That's the new number that would be generated, you can see it kind of – toward the top of the bottom half of the page there. That would be the kind of new information, and it will also give you the date and all those things for your records.

All right, if we go to slide 29, this is an example of a registration system from a State. So, if we selected Medicaid—just look two slides back—it will send all of the information we just put in to the State we select. So, whichever State this happens to be, it would go there, and then you would go to that State and you would see something along these lines. You know, you can already see some of the information's already in there—your name, imported over, and then you can see that. Notice there will be some unique things here. So, for instance, registration ID number from the State, you know, the State system will probably give you a different registration ID number. I assume it's almost guaranteed it will give you a different registration ID number.

Slide 30 talks about the additional Medicaid eligibility requirements that are needed. So, as Kathleen went over for Medicaid, it's not simply enough to be a nurse practitioner. You also have to meet certain patient volume requirements for Medicaid participation. So this is where you would go about – in this particular State, this is how you would go about doing that. So if you're an eligible patient volume, it's asking you to tell you which one. So in this case they selected “yes,” they were a pediatrician; “no, no, no,” they weren't on these other things. Do you render care in an FQHC/RHC? Yes. Do you want to include a managed care organization panel? They hit “yes.”

And then, you can see, it asks questions about the FQHC/RHC and managed care organization panels below. And then you would just fill all that eligibility information out. The thresholds in every State—you know, 30 percent for most folks, 20 percent for pediatricians, you know the, special rules for FQHC—those are – all the thresholds are the same from State to State. The actual way it looks on the registration screen, that would probably vary from State to State.

Slide 31 takes us to basically the signature page of this particular State to complete their registration. You accept terms and conditions just like you do pretty much every time you go to any Web site. Please do read those, they're not as long as the ones you got when you got your iPhone or Android, and then accept registration. And then you would get a success message. In this case, it's in the form of a green arrow up here in the corner on slide 31, you know – or as back on – you saw back on the Medicare system it looks a little different. But always, whenever you do get to that last page, you want to save that confirmation page that's in it forever, whether you print it out or save it as a file on a hard drive.

That's basically registration. You can do registration any time you want. You – registration is not an obligation to participate, and attest, and get paid, and all that stuff, in that given year. One of the biggest benefits of registration is, if you think you might be what we call hospital-based, by registering you'll get to find that out. I always tell people, don't guess if you're hospital-based. Don't spend your time and resources trying to figure out if you're a hospital-based or not. If you have any doubt, if you work in a hospital a lot, just register and you'll get told. No need to do any complex algorithmic studies on your own on the outside like some people have done in the past. Just register, find out. Registration also lets you – like what I was talking about earlier, make sure all your various identifying information is right across the systems.

So, if the taxpayer ID I want didn't come up, well, if I register early, I got plenty of time to fix that and add it into PECOS, or if I don't want to do it myself and I want somebody do it on my behalf, you know, I can find that out in registration and, you know, that person on behalf – maybe they register and the EP they wanted to attest for isn't there. Well, if they wanted to attest for them that day, that's a problem. You know, it's going to be tough to get that added in on the same day. If they were looking to attest for them 6 months from now, that's plenty of time obviously to get that information to me.

So, no reason not to register. There is no commitment piece. There's no charge for registering. There's no – nobody's going to pound on your door saying, "Why didn't you attest?" 2 weeks later. But if it is time for you to attest, you can move on to the attestation tab. And that tab starts on slide 33.

Attestation Overview

Most important thing to notice – see there at the bottom, you see a very similar attestation selection, kind of status screens. We're just getting started, mostly blank here. Obviously it's just imported over your name, your ID, National Provider ID. What I really want to call your attention to on this slide is the middle of the slide and the various things you can do with your attestation. Attest – and these are all – would appear in this action box, which is in the far right-

hand corner of your slide 33. So if you haven't attested before, so if you've never submitted an attestation or even started one, it will say attest.

If you started one before but didn't finish it, you can modify it. If you want to inactivate one before you got paid, you can cancel it. You can cancel it after you got paid, too, but that's more involved process than just logging in to the screen. Resubmitting—if you did get a failed or rejected attestation, you can resubmit. Reactivate if you canceled it and wanted – you know, say you found something that was going on but it's your 90 days and you canceled it, you can come back in a little later with a different reporting period, maybe it works out. And then, finally if you are all done, you can view what you did, as well.

All right. So getting started on attestation, slide 34.

There's really – there's two types of Meaningful Use measures as far as how it's going to look on your attestation screen. There is those that are essentially yes/no. It's going to ask you, did you do this thing? And then those are – then there are the percentage-based ones, which are going to ask for a numerator or a denominator, that's basically going to say, you know, of the things in the denominator, how many did you do the action that put into the numerator?

Slide 34 is an example of a yes/no functionality. You simply select yes, you can select no; obviously, you won't pass Meaningful Use if you select no. But you can and we have the option. We don't want to force people into not being able to move through the attestation screen just because that particular one they can't answer yes to. So, for instance if you were kind of – wanted to check on your percentages but you aren't ready to finish your attestation, you know, you can always put no and move forward. But when you're doing this for real and looking to pass, all the yeses will have to be yeses.

Slide 35 is an example of a numerator and denominator thing. So you'll see the denominator statement and the numerator statement right there in the middle. All of the denominators and numerator statements look like this. So the denominator will be, you know, the number of unique patients seen by the EP during the EHR reporting period, or it might be the number of medication orders during the EHR reporting period, or whatever it is. And the numerator will simply be the number of people, the number of orders, the number of whatever, in the denominator who have the action – for which the action has been taken that would move them into the numerator. And so all the denominator-numerator statements are set up for all the various measures. Other than differing statements and differing objectives and measures, you'll just see the same screen over and over for those numerators and denominators.

Slide 36 is a blow-up—so you can actually see it easily—of an exclusion. So some objectives and measures—usually, not always, and this is an example of a not always one—where the denominator would be zero—that's mathematically unfeasible. So that does – it's going to ask you, does this exclusion apply to you, yes or no? Not all objectives have exclusions so you won't always see this question, but a lot of them do and you'll see this question.

If the exclusion applies from you, then you basically get to skip that question and move on. If it doesn't, then it will ask you for your numerator and denominator statement. So to some extent,

this is a yes/no, but on this one you actually can answer yes or no, depending on your circumstances, and they'll be unique to the user.

Slide 37 brings us to a special case in the Meaningful Use measure sets. As Kathleen mentioned, they're divided into core and menu. In the menu for Stage 1 of Meaningful Use, all of the public health measures are in the menu. So to include public health, or to ensure public health was included in Stage 1 of Meaningful Use, we ask that you select at least one of those measures. So the example you see on 37 is for EP, there's only two: immunization reporting, syndromic surveillance reporting. Even if you meet the exclusions for both, on this screen you need to select one that you're going to attest to for the exclusion.

If you were to meet the exclusion for, say, immunizations but not for syndromic surveillance (i.e. you can do syndromic surveillance), you must select syndromic surveillance and vice versa, which is most likely the case since syndromic surveillance for eligible professionals is in fact common.

So after selecting that, you will see a screen just like you've seen before. It will ask you, "Did you meet the exclusion, yes or no?" If you say yes, you meet the exclusion, you will move on. If you say no, I didn't meet the exclusion, then it will ask you the attestation statement to which you need to answer yes, or you won't be able to be a user.

Right, slide 38. This is the final question, if you will, on the Meaningful Use as opposed to the clinical quality measures. Some of the measures are rather complicated. And for those that have complicated denominators, let's say – well, the numerators are probably always kind of somewhat complex because you have the numerator action. But some of the denominators are really simple: I saw this many patients. Some of the denominators are rather complicated: I saw this many patients in this age group, or I saw this many patients who had at least one medication on their medication list, or I saw – or I gave this many lab orders of this type.

For those more complicated denominators, we allow for a distinction between basing your measures on all of your patient records or only those patient records that you use certified EHR technology for. It's certainly possible that you might have a situation where – and workers' comp is, you know, by far the most common example. Or maybe for worker's comp cases – workers' compensation cases, you have key paper records but everybody else goes in your EHR.

For most of you in 2013 – you know, in 2011, this might have been a different conversation, but in 2013 most of you will be hitting the first button. There is no distinction between all your patient records and your patient records in your EHR. But for those few of you for whom there is a distinction, there is this option for some measures. Just because it's not theoretically possible – or I guess it's theoretically possible, it's not practical to, say, comb your paper records and find out how many medications you ordered over a year time period. You know, this is the benefits that IT provide and sometimes you need IT to do it at all.

All right. Slide 39 is – now we're moving to clinical quality measures, which is the other piece, you know, the other type of measure. The first question you're going to ask is whether or not you want to participate in the PQRS, Physician Quality Reporting System pilot. So this is electronic

reporting of measures as opposed to typing them into the system. Your EHR is going to generate a file that has your CQMs, and that will be, you know, sent through either a registry to CMS or CMS directly. And basically that piece, if you're doing that, is – your vendor will worry about those submissions, and you'll work with them on that submission.

You know, the slide in front of you, 39—it says 12, obviously if you're going to log in today, the live screen would say 13, it's 2013—you can still participate in the pilot. It will ask you this question. Please, please, please know that you're submitting in the pilot when you say yes. Don't say yes and that – with the idea in your head of yes, this sounds really neat, so I'm going to say yes now and then go figure about it later. If you're interested in the pilot and you're not participating in it yet, and you want to participate for this year, kind of stop your attestation here, go find out about the pilot, talk to your vendors, see if you can participate, and then come back and attest.

So it's important to know that – you know, if you're hitting that – when you hit that yes button, you want to know that you can participate in the pilot and your EHR, the person you bought it from is somebody who's doing that and working with that. So, not to discourage you from the pilot at all, just saying if you want to participate in the pilot and you don't know for sure that you are, this is where you stop until you're sure that you are.

All right. So if you say yes, it will bring you to the screen that basically allows you to submit all your measures, and you'll see your summary pages toward the end. If you say no, as selected on slide 39, then it's going to ask you to manually put in your clinical quality measures, and you can see an example of that on the next few slides.

So on slide 40, let's call this the – simple is not the right word, but the least amount of information CQM, you know, the bare minimum, if you will, of any CQM information, where you just have one denominator and one numerator.

All of this information – unlike Meaningful Use, where we want you – or the idea is that you don't have to take what came out of your system. If you get some numbers for your problem list out of your EHR and you know they're wrong because of this reason or whatever, or you wanted to add in a few paper records, or, you know, for whatever – you could modify those, and we want the most accurate numbers. You're attesting to the actual accuracy, that denominator/numerator absolutely accurately reflect your patient population.

For clinical quality measures, that is still a goal; by far, that is where we want to do it. But what you're actually attesting to is that what you're putting in is the output generated by your electronic health record. Still want it to be completely reflective of your patient population, it's just the way we want you to get there is by working with how it's measured in your EHR and making that better, as opposed to adding on at the end after it came out of your EHR.

So for clinical quality, put it in as it comes out of your EHR, and what you're attesting to is that those things match. What came out of my EHR is what I put in into the system. If it doesn't accurately reflect your patient population, that means you need to work on – with your vendor on

making that so, but that's not a problem you have to solve before you can attest to Meaningful Use. All right.

Slide 41 shows you a slightly more complicated CQM, the two denominators and numerators—I don't know, Maria, how high does it go?

Maria Michaels: Three...

Travis Broome: Yes, I guess so. The – you'll have – potentially could have up to three denominators and numerators for a given CQM. But again, you should be getting that report out of your EHR, matching it up, and putting those numbers in.

And finally, slide 50 – or 42, all it shows measures, in this case, again just two denominators and numerators, but also exclusions. So a lot of times you might have patients who are giving clinical quality measure that are in the denominator, but there's a very good reason that you shouldn't take the numerator action for a given patient—you know, it's contraindicated.

And rather than getting, you know, quote unquote dinged on – by just having that person being in the denominator and not being in your numerator, there is an exclusion criteria that allows you to take out those contraindications, and for other reasons, as well.

As – so that's as complicated CQMs get, you know, it's – again, you're just transposing from that EHR report, moving forward, and then basically doing continuous improvement on trying to make that report as accurate of your patient population as you can.

Slide 43, this is your additional CQMs. So the way CQMs will work in 2013—this changes in 2014 for everyone, unfortunately—but if you're attesting in 2013, which is our focus here today, you'll do three core or – measures, clinical quality measures. If you – they are not applicable to you, there's three more to pick on, called the alternate core. So there's that group of 6 and then there's another group of 38—thank you, Maria—total, of which you need to pick 3 more. And what you see on slide 43 is those options picked, that's how you pick. So there's – they're obviously not on this slide, but there will be 38 of these guys, and you hit select on 3. And you will see screens just like we went over for those three before. So if it has three denominators and numerators, you'll see that and you'll just input those, as well.

Slide 44, we start off with the bad news—we'll see good news, don't worry, in other things—a rejected attestation. An attestation could be rejected because maybe you didn't fill something out. So maybe you only selected two CQMs, or it could be selected because when the system does the math, the threshold was 80 percent and you only scored 75 percent. Maybe you hit no on a yes/no that you had to hit yes on.

It's not a mystery, though. As you – as it says there on – in the middle of the slide, it says, “Select the summary of measures” to view all your measures and what they look like. So if you go to slide 45, you will see that summary of measures, and it will give you all of the information they have, so what you put in for various things. So you can kind of go through here and say – well, this is a passing one here so I can't really give you a good example. But let's say on the

second one down on slide 45, you said no, that you hadn't enabled your drug-drug and drug-allergy interaction check, and you go, "Wait, yes, I did that, I just hit the wrong radio button back then." You can hit the edit button there and go back and change that. So you will see this summary statement whether you successfully attest or unsuccessfully attest. In either case you will get the summary statement; certainly encourage you to keep that, print that, save that as a file so you have it for your records.

All right. So there's – as I kind of joked about at the beginning, there's certainly a lot between determining you're eligible and attestation. I mean, you've got to acquire an EHR, you know, understand Meaningful Use, know all the objectives and things to be able to get to the points we've covered in this presentation.

Resources

Most of our resources are available on slide 47. You can see the links there on our Web site, which is just cms.gov/ehrincentiveprograms. You'll see tons of resources on there, all the way from, you know, intro guides, how do I get started, how do I select an EHR, you know, what do I know about Meaningful Use. All – you know, there's a calculator, so if you don't want to do it on the Web or you're worried about doing the official system, there's a calculator that lets you find out how you're doing, it kind of simulates the attestation process for you.

Now, all the way to the actual regulations. You know, I'm the guy who works on the regulations, so I actually encourage people to look at them. Just remember, Control-F is your friend, you know, so if you have a question about computerized provider order entry, you don't have to read all 250 pages. You've just got to control-find "computerized provider order entry" and that particular section is only like three pages.

The other link that's on slide 47 is what I referred to earlier – was talking about earlier, on getting your CMS certification numbers, so that number that's unique to you and your EHR combination versus the number of the person who gives you – sold you the EHR gave you. This is the Web site where you go to convert that number or get that CMS EHR certification number, the CHPL, as it's known.

And then on slide 48, you can see it as a troubleshooting slide, so if you get stuck or have problems with any given point, these are where you can reach out to for help. The EHR information center help desk—obviously if you have a question about Meaningful Use, if you have a question about, you know, how to attest or your actual attestation, things like that, that's where you would want to go. If you can't even log in to the system because you don't remember what your NPES account is and your NPI username and access, there's the NPES help desk there.

And then if you can log in but you don't see the taxpayer ID number that you want your incentive payment to go to, that's something you need to correct in our Medicare enrollment system, known as PECOS. And all those information are – information support things are there on slide 48. And finally, slide 49 has again more – a list of user guides and resources, and again these are all available. I think these are hyperlinks.

Diane Maupai: These are actually live links to that attestation calculator and some worksheets and the user guides, those things that you might find really helpful.

Travis Broome: Right, well, with that I'll turn it over to Diane to finish up any resources and kick off the Q&A.

Question-and-Answer Session

Diane Maupai: All right, well, thank you, Travis. We're now going to take some time for your questions. I want to let you know we've been joined by Maria Michaels, who's an expert on clinical quality measures, and Tom Novak, who's an expert on the Medicaid incentive program. Before we begin, I'd like 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.

And in an effort to get to as many of your questions as possible, we ask that you limit your question to just one. We know that's hard. If you would like to ask a followup question or have more than one question, you may press star 1—that's star 1—to get back in the queue, and we'll address these additional questions as time permits.

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

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to 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 Joan Taylor.

Joan Taylor: Good afternoon. This is Trinity Health, and we have a question regarding the attestation user guide that is posted on the CMS Web site. It is dated to July 2012; however, we've recently begun doing some attestations on the portal, and the screenshots of the portal today do not match those from the guide posted from July 2012, and we'd like to know when the guide will be updated and posted on CMS.

Travis Broome: We're working – we don't have a precise date for you. We're working on getting the guide updated to reflect the current screenshots, or with updated screenshots from the changes that were made for 2013. For instance, it's no longer required to do the test of exchanging key clinical information. That's a work in progress, unfortunately the – it's almost harder to update those static documents than it is the actual systems live; you've got more interactive that – things in the system itself. So I can't give you a precise date, but hopefully very soon.

Yes, and I would just encourage you to play in the system itself. I mean it – you know, as long as you don't hit that final button, you can change, mess, you know, everything you want to within the system itself.

Diane Maupai: Thanks, Travis. We're ready for our next question.

Operator: Your next question comes from the line of Sonya Smith.

Sonya Smith: Hi, this is Sonya Smith with LifeStream Behavioral Center. We do – we have a behavioral health freestanding psychiatric hospital. And my question is on the hospital-based EPs that are not eligible. When we bill, our place of service code is 51 for a psychiatric hospital. Does that also mean that those doctors – EPs are not eligible, because it is a hospital-based?

Travis Broome: No, the statute that created the HITECH Act is very specific about what type of hospital. So that is just – it's POS 21, which is an inpatient department of acute care hospital, and 23, which is an emergency department. Whether they're truly outpatient or not, all other locations for purposes of the EHR Incentive Program are treated as outpatient, or ambulatory, even if, you know, in – like you said, in your case they might not actually be in reality...

Sonya Smith: Right.

Travis Broome: ...But the definition for hospitals is very narrow, and therefore the definition of everything else is very broad.

Sonya Smith: So those doctors that work fully in our psychiatric hospital and don't do any what we consider outpatient services, I can still do an incentive on them.

Travis Broome: Yes, I believe that is the case, and can be confirmed, like I said earlier, just by going and registering.

Sonya Smith: OK, and that, I was – I wrote that down when you said that, so the registration process would tell me that even if we are doing Medicaid attestation?

Travis Broome: Yes.

Sonya Smith: Would that matter? OK. I didn't know if that part of it mattered whether – we're doing the Medicaid.

Travis Broome: Yes, it will take you to your State when you register, and your State will give you that same information.

Sonya Smith: Oh, OK. OK. Thank you.

Travis Broome: You're welcome.

Diane Maupai: Thanks, Travis.

Operator: Your next question comes from the line of Michal Krell.

Michal Krell: Hi, my name is Michal from HCN. One of our centers applied to Medicare last year, and this year for year two they change their electronic health record system in more or less – this month actually, they’re going to change it. So the question is how they are going to apply for next – for this year, which system should they use?

Travis Broome: Well they – so they applied last year, so they’re going for this year, which means they have a full-year reporting period in 2013.

Michal Krell: Yes, so my question here ...

Travis Broome: Basically you’re going to use a combination of your systems, so you’re going to – just take the data from your old system. So let’s say – when did you switch over?

Michal Krell: The switch will be probably beginning of June.

Travis Broome: OK. So, you’ll basically just take the numerators and denominators from now till June from the old system, the new ones from the new system from June through December, and literally add them together. There is the Frequently Asked Questions, which in our parlance is known as subregulatory guidance, an FAQ that basically gives you the leeway, if you will, that you don’t have to reconcile anything across those numbers.

So if you saw the same patient on both ends, you know, technically under the term “unique patient,” you know, they should only be counted once, but we don’t require – like I said, there’s some guidance out there in our FAQs that were linked to – well, not this specific one but the FAQs in general were in the links and the materials that will allow you to just simply add those things together. And when you go to get your CMS certification number, you would just put in both, both systems...

Michal Krell: Both?

Travis Broome: ...in the CHPL, yes. And you just put in all the numbers you got and that will be that. So, yes.

Michal Krell: OK, thank you.

Operator: Your next question comes from the line of LaChrissa Patrick.

LaChrissa Patrick: Hello. I wanted to go back to slide 39 and address what you were saying with the pilot.

Travis Broome: Yes.

LaChrissa Patrick: Are you there?

Travis Broome: Yes.

Diane Maupai: Yes, we're listening.

LaChrissa Patrick: OK. Can you help me understand again when you were saying the options, if you hit yes, this is allowing you to submit the measures when you are utilizing the pilot for PQRS, is that right?

Maria Michaels: This is Maria, I can answer that. When you choose yes for the pilot, you have to submit your measures using one of the EHR reporting options in PQRS. So you basically submit them in the same way you would submit to PQRS, and you would go there and follow those instructions to upload your file. You would need an IACS account to be able to get in – to log in to that system.

LaChrissa Patrick: OK. I guess I'm confused, because I have an IACS account, and from what I understand this is where we would submit those measures for PQRS. But with this option here being a pilot, if you're saying yes at this point, does this basically stop this process? And then you complete the...

Maria Michaels: It stops the attestation process in this system and then you would go to the system that used – used for PQRS, as well. If you're eligible for that program, you may be familiar with it. If not, we will do a better job of trying to explain the process of getting there. But again, it's just the EHR reporting option for PQRS. So, for example, if you're participating in PQRS and you use their claims option, that's not available for the pilot. If you use the registry option, that's not available for the pilot. The only – the only options are to use the EHR Direct, which is basically, you as the EP would directly take the files from your EHR and upload them. Or you could use a data submission vendor to take those files for you and then upload them on your behalf.

LaChrissa Patrick: OK.

Maria Michaels: Does that answer your question?

LaChrissa Patrick: Yes it does, thank you, Maria.

Maria Michaels: Great.

Operator: Your next question comes from the line of Vicki Thompson.

Nikki Thompson: Hi, my name is Nikki Thompson and I work at St. Francis Physician Services. I have a practice who is attesting their first year 2013. My question is, do they need to progress to Stage 2 in 2014?

Travis Broome: No, they would progress to Stage 2 in 2015. No matter when you start, be it 2013, be it 2016, be it 2018, you always get 2 years of Stage 1.

Nikki Thompson: How will they – when they attest for Stage 1 next year, how will they differentiate on the tool? Or will it filter it out automatically, I suppose, because, you know, the benchmarks are different?

Travis Broome: Yes, the benchmarks are different. There's the – the tool, starting in 2014, will basically have a Stage 1 track and a Stage 2 track. And because everyone who's either coming in for the first time or the second time will go on a Stage 1 track, which will look a lot like what we just saw, and everybody who's coming in for the third time, or the fourth time if they started in 2011, will be sent down the Stage 2 track.

So the system knows based on how many times you've been in, which track you should be on, and you won't even see the other.

Maria Michaels: And this is Maria. That was related to the Meaningful Use functional measures. On the clinical quality measures, they change by year, so no matter which stage you would be in, say, in 2013 or 2014 or 2015, the CQMs that you would be reporting would be based on the CQMs that are being reported across the board for all EPs.

Nikki Thompson: I understand.

Maria Michaels: OK.

Nikki Thompson: Thank you.

Operator: The next question comes from the line of Andrea Barrett.

Dr. Lichten: Hi, this is Dr. Lichten, Central Ohio Plastic Surgery. Question is for – on slide 37, you talked about the public health quality measures and said that you had to – we had to select one of the two. The question was whether you are eligible or not eligible. But I thought you said something – if you're eligible for one and not the other, you have to select the one that you're eligible for. And the question is, what if you're – I mean, eligible from exclusion, I guess. If you are – what do you do when you are excluded from both, or meet the criteria for exclusion for both?

Travis Broome: Right, it sounds like you likely would be with your specialty. You can just select one. You don't have to select them both, and by attesting to the exclusion, you kind of cover both of them. You're not precluded from selecting both and using up kind of two of your menu objectives. But we certainly encourage you to focus on things that are more relevant to your practice from the menu. So you can just select one and so, it wouldn't – you would – I mean, you would just, when you select one or both, you would be presented with the exclusion question first for either one. And when you hit exclusion, it would just move you along.

Dr. Lichten: But it doesn't hurt you to select – if you excluded from both, it wouldn't hurt you to select both and exclude from both. In that particular – yes, we want to focus on things that are more relevant to practice.

Travis Broome: Right, but it doesn't hurt you. There's nothing precluding you from doing that, short of me encouraging you not to do it.

Dr. Lichten: OK. Thank you.

Travis Broome: OK.

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

Jennifer Rose: Hi, my name's Jennifer Rose with Duke University Hospital. I just had a question. If we're going to be attesting on behalf of many, many providers, is there an easy way to register multiple providers, or do you have to go through that same process individually each time?

Travis Broome: Right now you do have to go through each process individually each time. We're working on – we actually had a meeting about it this morning, on coming up with a – what we'll call a batch reporting, where you would create one file for the Meaningful Use attestation so you wouldn't have to walk through all of those screens, and upload it. But it doesn't – that won't be available until, I think, what – January, beginning of January. So it – that – it will be available in time to attest for 2013 folks, but not for a while yet.

So, you know, it's kind of up to you whether you wait or go through it now.

Jennifer Rose: OK.

Travis Broome: We totally understand and we're trying to mitigate, you know, the time taken, but, you know, since everything's done on an individual EP basis, that's just where we ended up to begin with.

Jennifer Rose: OK, thank you.

Tom Novak: Some of your State – if you're doing Medicaid also, some of your State requirements for demonstrating patient volume – there might be some efficiencies there, like sometimes some States will generate a template that sort of covers the whole practice if you're using the group or – the group patient volume ...

Jennifer Rose: OK.

Tom Novak: ... attestation method. So you might some – see some efficiency there.

Jennifer Rose: Thanks.

Diane Maupai: Thanks, Tom.

Operator: Your next question comes from the line of Debra Farley.

Debra Farley: Yes, my name is Debra Farley with BILLPro Management Systems. In the last few months, we have been investigating an issue with one of our clients who recently changed from a sole proprietor to a disregarded entity LLC. As a sole proprietor, he was eligible and received the EHR incentive payments for 2011 and 2012, but now as a disregarded entity LLC, he's not eligible for an organizational entity to NPI, therefore he cannot reassign his benefits. And now we're finding he's not eligible for the EHR incentive. We're trying to get answers to this. We've looked on Frequently Asked Questions. Can you help us?

Travis Broome: So, I've never heard of what would – that specific type of LLC. I mean, we take – is he – are his claims – is he be able to reassign his claims, if you know?

Debra Farley: No, you don't reassign the claims. Medicare considers – it's considered like a sole proprietorship, only an individual in enrollment. A disregarded entity isn't – even though he's an LLC, is not entitled to an organizational or entity to any – therefore, he's not able to reassign his benefits. There is nothing to reassign. And he's tried to re-attest or get prepared to re- – to attest for this year's incentive, and he's not going to be able to. And we've talked with our MAC contractor, I've tried to get answers from CMS directly, the EHR people, and I cannot get a direct answer, and we don't know how to help this provider. And I'm sure he's not the only disregarded entity in the Nation.

Diane Maupai: It sounds like you have – this is Diane. It sound like you have a rather specific case, and I thought I would ask you to send the information to our resource box. It's National Provider Calls—that's calls with an S, plural—at cms.hhs.gov, nationalprovidercalls@cms.hhs.gov, and we'll look into your case.

Debra Farley: OK, can you give me that one more time, the e-mail?

Diane Maupai: Sure, nationalprovidercalls@cms.hhs.gov.

Debra Farley: Thank you so much.

Diane Maupai: You're welcome. Next question?

Operator: Your next question comes from the line of Deb Eulberg.

Deb Eulberg: Hi, this is Deb Eulberg with Dayton Gastro. I have a question on one of the core measures for providing a clinical summary to patients for each office visit. Is that limited to E&M services? For instance, if the provider provides surgical services in an outpatient setting, are those visits included in that denominator?

Travis Broome: So, it's not limited just to the E&Ms. It's limited to what we describe as office visits. There's an FAQ on what defines an office visit and it's in the rule as well. And it's basically any – consultive visit with significant patient interaction. There – I – basically, it's out there that there's guidelines – our main concern, right? You know, kind of thinking of it from an – you know, if somebody were to – an auditor were to show up or somebody else were to

question you on your decision. There is some latitude in there, so I encourage you to kind of look at those, that definition. It's not very long. It's like a sentence and a half.

Deb Eulberg: Yes, yes.

Travis Broome: And we're – you know, if it's in a gray area, we're not necessarily concerned with where you ended up in the gray area, but rather that it was consistent.

Deb Eulberg: OK, all right.

Travis Broome: So, you know, if you're going to count surgeries, count surgeries. If you're not going to count surgeries where, you know, they don't even see the doctor because, you know, they go down before he gets there and they're – and he's gone before they wake up and stuff, then, you know, don't count them. But you know, just be consistent on your interpretation of that – of what an office visit is.

Deb Eulberg: OK. OK, thank you.

Operator: Your next question comes from the line of Donna Becker.

Donna Becker: Hi, this is Donna Becker calling from Spokane Respiratory Consultants. My question is regarding the functional measures 9 and 10 – I know there was already a question on it. And last year, we did our 90-day attestation and we set up our link with the State. But this year, going into our full 12 months as Stage 1, we had stopped giving our Pneumovax injection, so I need to figure out how we're going to meet that measure.

Travis Broome: I mean, if your pneumococcal vaccine was the only vaccine you were giving – or immunization you were giving and you stopped doing that, then you would probably meet the exclusion this time because, you know, there's an exclusion for EP gives no immunization.

Donna Becker: OK, then would I have to do number 10 – the other one?

Travis Broome: Well, you can't – yes, you would have to look into number 10, syndromic surveillance. There are only two counties in the country that I'm aware of that eligible professionals can actually submit syndromic surveillance: one of them's Tarrant County in Texas near Dallas, or Fort Worth, and then the other one's out in California, I forget the actual name of it.

Donna Becker: So we would be excluded from that one, as well.

Travis Broome: Most likely, yes.

Donna Becker: OK. OK, so what we've done so far this year is – I've actually talked to our providers, and they've ordered like a minimal amount of the Pneumovax so – since I already had the link set up. So is there a minimal amount and how's that going to affect us?

Travis Broome: There's not a minimal amount. So if – you know, if you ordered – you know, did 10 and you had the link set up and you report 10, then you'll be attesting yes and then ...

Donna Becker: OK.

Travis Broome: ... assuming next year you drop it all together, then you would move into the exclusion realm.

Donna Becker: OK, perfect. That's what I needed to know. Thank you.

Operator: Your next question comes from the line of Rose Long.

Rose Long: Yes, hi. I'm from North Shore-LIJ Health System. My question is in regard to a physician who is participating in the Medicaid program – incentive program but also happens to have Medicare payment. Is there a requirement for them to submit their – and attest on Medicare side to avoid a 1-percent penalty?

Travis Broome: No, if they're attesting to Meaningful Use—not adopt, implement, and upgrade, but if they're attesting to Meaningful Use on the Medicaid side, to the State, that information is sent to CMS. Not all the gory details about individual attestations but the fact that they successfully attested is sent to CMS, and that will avoid the payment adjustment for them.

Rose Long: Thank you.

Operator: Your next question comes from the line of Monique Milton.

Monique Milton-Dent: Hello, my name – oh, are you there? Are you there, can you hear me?

Maria Michaels: Yes, we can hear you.

Monique Milton-Dent: Oh, thank you. Oh, my name is Monique Milton-Dent. I'm the Medicare Part B Billing Specialist for Genoa Healthcare. Question is, we specialize in mental health. We have over 120 pharmacies nationwide. I bill specifically for Medicare – the Medicare Part B and the paper billing. My question is, our patients, as you say – they do not – we can't qualify – I don't know if we qualify because we've never done this before. We cannot contract with Medicare, we cannot contract with the MCOs simply because we're pharmacists that are administering medications specifically dealing with mental health.

So how would we qualify, first of all, for this program and can we – since the managed care plan transition has come into about 80 percent of our patients, which are also Medicare qualified—once again Medicare doesn't deal with mental health—can we qualify them on the basis of the blood draw, which is now falling under the umbrella of medical service?

Travis Broome: I think – so the short answer is, you know, the law was very limiting on who could participate. It's a specific set of acute care hospitals and then this certain group of eligible

professionals. So if you – eligible professionals are not an eligible type, you know, nurse practitioners, them ...

Monique Milton-Dent: So we're specifically pharmacists...

Travis Broome: Yes, if they're only pharmacists then unfortunately they're not in the EHR Incentive Program. If you have other professionals who aren't pharmacists who, you know – back on the slides, I forget which ones they were – the eligibility slides – seven...

Monique Milton-Dent: We're transitioning our labs. We do a blood draw and a supervision, you know, for the distribution of the medication, Clozaril (clozapine). So we're transitioning all of our blood draws over to our labs, and that is now considered a medical service, which is now going to be billed through their medical coverage under their managed care plans. Would that be...

Travis Broome: Well, yes. It's – it doesn't – for eligibility, it doesn't matter what they bill. It matters who they are ...

Monique Milton-Dent: OK.

Travis Broome: ... unfortunately. Sorry, I don't have better news. I'm sure you get that answer a lot. But we can't control that part.

Monique Milton-Dent: So none of them are going to work out. OK, thank you so much.

Travis Broome: You're welcome.

Operator: Your next question comes from the line of Wayne Lewis.

Wayne Lewis: Yes, this is Wayne Lewis with the North Carolina Regional Extension Center, and I just wanted to make a comment about the ONC certification number. I don't know if it is the same in other States, but North Carolina, on their attestation Web page, does not have a place to enter the ONC certification number. So it has to be entered in on the CMS registration site, and it can take 24 hours or more for that number to come across if there's not any problems. So providers that do not enter it in during registration, at least in North Carolina, if they're coming up on a deadline, can run into some issues on that, so I just want to make you aware of that.

Travis Broome: Thank you very much and that's a very good point. I don't know how many States – I don't know if Tom does, operate similarly as North Carolina does, but again, that's kind of a good reason to not wait towards the last minute. And I know we had a few providers who literally last year—attestation for 2012—literally, it took longer than they thought just to punch in the numbers, and the clock ran out on them.

So I highly encourage you to—especially on the registration side—to do it well ahead of time. And really, there's no reason – if you have the number, certainly no reason not to include it – to

go and include it the first time around. Tom, I don't know if there's anything you wanted to add to that.

Tom Novak: Yes, I – even maybe a little further and say like, if you're planning to attest like, you know, look at your NPES, look at your NPI, look at your PECOS number, like, you know, there's a bit of prep work you can do. So even if you're not necessarily ready to pull the trigger, to make sure you don't get, you know, sort of stuck in this situation where you waited to the last minute, those are some of the things that you need to have ready when you go to attest, otherwise you could be in that situation Travis talked about where people wait until the last minute and then, you know, one day, the element isn't there. They have to like, you know, make some calls to straighten something out and then they miss the deadline.

Travis Broome: Thank you for bringing that up.

Operator: Your next question comes from the line of DeeAnne McCallin.

DeeAnne McCallin: Hi, this is DeeAnne McCallin with CalHIPSO of Regional Extension Center. And my question is on behalf of about 10 eligible professionals who have been designated hospital-based. We haven't been able to find a resource to appeal that. We've had people through CMS who have been able to look it up and tell us why it was designated, but we can't get past that, saying "but here's other information as to why." So we're looking for how to change or appeal a hospital-based designation.

Travis Broome: So the short version is that that designation isn't appealable. It's a – it's basically based on Medicare claims. I'm trying to do this quickly. It's based on Medicare claims from the previous fiscal year and it's just math. You know, you have so many encounters and it's divided, you know.

We have – there have been situations where the – you know, say the claims were late or there was a mass adjustment of claims by a hospital or something like that, that has changed the calculations. But the claims themselves – you know, the only two things that would go wrong, neither of which are appealable per se, but we can work with you on it if you truly think we got the math wrong, which is unlikely that we would get the math wrong for – you know, if we get it wrong, we need to run it for lots of people, right? It's the system formula. If there's a system error it'd be wrong – or there was a specific mass claim adjustment event. So if you did have such an event, more than happy to you, but there is no substitute for that information that can be substituted. Instead of using the claims from the prior fiscal year, we will use this information. That's just not something that's appealable.

DeeAnne McCallin: So if I thought I had something to go for that, where should I – where should I try to take this information?

Travis Broome: You can just send in the specifics to the, you know ...

Diane Maupai: At nationalprovidercalls@cms.hhs.gov.

DeeAnne McCallin: OK, great. Thanks.

Operator: Your next question comes from the line of Tracy Szabo.

Tracy Szabo: Hi. Sorry, I had to come off of mute. My question relates to an FAQ that was on the CMS Web site not that long ago. And it was FAQ number 82-31, and I work for Tenet Healthcare Physician Practices, and that FAQ was regarding, while the denominator for measures used to calculate Meaningful Use in the Medicare and Medicaid EHR incentive program is restricted to patients seen during the EHR reporting period, is the numerator also restricted to activity during the EHR reporting period, or can actions for certain Meaningful Use measures be counted in the numerator if they took place after the EHR reporting period?

And the CMS FAQ said that the criteria for a numerator is not constrained to the EHR reporting period unless expressly stated in the numerator statements, and that the numerator for the following Meaningful Use measures should include only actions that take place within the EHR reporting period. And it says preventative care, patient reminders, and secure electronic messaging. And then it says for all other Meaningful Use measures, the action may reasonably fall outside the EHR reporting period timeframe but must take place no later than the date of attestation in order for the patients to be counted in the numerator. Now, that particular FAQ when it launched has caused a little bit of confusion in my market because when we generate our reports for Meaningful Use, for our threshold objective measures, they're looking at time parameters. There's no way for me to select a time parameter after the reporting period for just the numerator portion.

So I just want someone to explain, what exactly does that mean? So for all except for the two – the menu objective patient reminders and – I can – there can be an action taken after the end of the reporting period up until attestation? And I'll give you an example. If I have a provider that's doing – let's say they're doing a Quarter 2 reporting period for Medicare program year one this year and that – let's say they picked April 1st to June 29th, they can – if they choose to attest next year, say mid-February before the deadline, they could use those patients that were in the denominator all the way up until that date that they attest in February the following year?

Travis Broome: Right. So, the reason for that FAQ is that it recently came to our attention that a lot of vendors had added this non-regulatory limitation of the numerator action has to occur during the reporting period. That was never in the regs. It just – it turned out that a lot of vendors just interpreted that way and designed their systems that way.

I'll give you an example of an easy case of when it might be. So say you discharged a patient on the last day of the reporting period, and you have a policy of, you know, the physician signs off on the discharge instructions before they are put up on your patient portal. Well, if he doesn't sign off until the next day, you're out of luck. But the reg gives you 3 days to get them up on the portal. So obviously, I mean, you know, to be fair, we would have to give you at least the 3 days after the reporting period for that particular measure, or we're basically saying you're just out of luck for these guys. And there – so it's a regulatory construct of – we didn't put it on limitation.

Another example is coding. So a lot of times you might have patients – do a problem list on a patient, but they're not in the right code, the code might happen much later. So you have coders come through once a week, or whatever it is. We expect most of the actions would normally occur very quickly. But there is no regulatory time limit on these things. It's just the practical time limits of got to do it before you attest or otherwise your attestation wouldn't be truthful. If there is a time limit, like I've mentioned, 3 days, you've got to do it within the time limit. Some of them have true practical limitation—e-prescribing. Obviously you're not going to write an electronic prescription for a med you ordered 6 months ago. But there is no regulatory limitation, never has been. It just came to our attention recently that lots of vendors thought there was, which is why we put out the FAQ.

Tracy Szabo: So is this FAQ geared for hospitals or eligible professionals?

Travis Broome: Both.

Tracy Szabo: Both. So essentially, if my provider wanted to screen patients for smoking cessation, if they didn't do it during the reporting period, they would use that same denominator population if they saw the patient again in a – throughout the year, and they could still essentially get credit for it?

Travis Broome: Sure. So to use your smoking example, I see a patient for a very low-level – level 2 visit in February. We don't talk about smoking, we don't do anything else, we did the one thing they came in for and they moved on. And there was – so I didn't put anything in for smoking, it was just blank. They come in, before I attest, later for another visit, and I add in smoking and that comes after, that's – yes, it's not – it's not ideal but, you know, that's a good example of a way that could come up with, you know, kind of cleaning up records.

Actually it's a pretty good example, I hadn't thought of it before. But that's an – exactly a thing that could happen. You know, so it's – the time limitations, except for the three you mentioned—we went through this again—all apply to the denominator. Once they're in the denominator, the only time limitations, except for the three where it's explicit, to the numerator, are practical—you know, before the attestation period, e-prescribing, things like that. There are no more regulatory limitations.

Tracy Szabo: OK. Nice. Thank you.

Maria Michaels: Wow. I don't think very many vendors have a way to do it this way, quite honestly.

Travis Broome: We are well aware of that, and we learned that at basically at HIMMS a couple months ago, and that's why we're trying to do the education now.

Diane Maupai: Thanks. We'll take our next question.

Operator: Your next question comes from the line of Terri Henning.

Wendy Hollerman: Hi. My name is Wendy Hollerman speaking on behalf of Terri, and we have a question as far as, we are professional physicians that work out of the hospitals, and we are not employed by the hospital. Therefore, we have no ownership in the equipment in the hospital as far as in requesting an EHR cert number. If we have no ownership in the equipment, and we work out of multiple – multiple different hospitals, how are we supposed to do this?

Travis Broome: So, you know, if you're not hospital-based, but you're doing enough outpatient that you're not hospital-based, but you're basically relying on EHRs provided by the hospitals, you are still eligible – you're still able to go about the incentive payments. Although it sounds like in your situation, you are dependent, if you will, on the good will, I guess, of the hospitals to get the information from them.

Wendy Hollerman: Right.

Travis Broome: CMS has no mechanism, you know, no legal mechanism to force a hospital to provide you that information. It would have to be done through your negotiations with the hospitals.

Wendy Hollerman: OK. Because we've been trying to get an answer to this, and, you know, we've called the hotline, and they had given us a reference number and was going to go to like a third level with this to get us some answers. And obviously, they have not gotten back to us, and that was like 2 weeks ago.

Travis Broome: Sure. Well, the third levels, when they can't figure it out, they send it to us, and there's your answer.

Wendy Hollerman: So it's basically, we are – we are stuck if the hospital doesn't want to cooperate and give us the information that we need.

Travis Broome: Yes, like I said, we – there's – you know ...

Wendy Hollerman: OK.

Travis Broome: But, we need specific authority to force people to do things and ...

Wendy Hollerman: Right.

Travis Broome: ... they don't even have one remotely related to be able to do that.

Wendy Hollerman: OK. I understand.

Travis Broome: All right?

Additional Information

Diane Maupai: Unfortunately, that's all the time we have for questions today. If we didn't get to your question, I would refer you to the slides of 47 to 49. They have a lot of good information, including the contact information for the Help Desk. And if you look on slide 47, that has the overall CMS HITECH or EHR Incentive Program Web site. If you go on the left-hand side, the very last tab is Frequently Asked Questions, FAQs. And it seems like if you look there, you might find your answer.

I'd like to thank you for participating in the call today. Don't forget to mark your calendars for the other calls in this series. They are listed on slide 4, and you can register now for the call with the Office of the National Coordinator on certification on June 27th.

On slide 51 of the presentation you'll find information and a URL to evaluate your experience with today's call. Evaluations are anonymous and strictly confidential. You will get a reminder e-mail from CMS National Providers Calls within 2 business days regarding the opportunity to evaluate the call. Just disregard that e-mail if you've already completed it, and the evaluations will be available for completion for 5 business days after today's call. And we really do appreciate your feedback.

An audio recording and written transcript of today's call will be posted soon to the CMS MLN National Provider Calls Web page. Again, my name is Diane Maupai. It's been my pleasure serving as your moderator. I'd like to thank Kathleen and Travis and all of the folks that helped answer questions. So thanks and have a great day, everyone.

Operator: Thank you for your participation in today's conference.

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