

**Centers for Medicare & Medicaid Services
Meaningful Use: Stage 1 and Stage 2
National Provider Call
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, ma'am. You may begin.

Announcements and Introduction

Diane Maupai: Thank you, Holley. Good afternoon, everyone, and thanks for joining us today. This is Diane Maupai from the Provider Communications Group here at CMS in Baltimore, and I'll be serving as your moderator for today's call on Stage 1 and 2 of Meaningful Use. Today's National Provider Call is part of the Medicare Learning Network, your source for official CMS information for Medicare fee-for-service providers.

Before we get started, there are a few items I'd like to cover. The link to the slide presentation for today's call was e-mailed to all registrants around 12:30 today. If you didn't get that e-mail and you don't have the deck, please check your spam or junk mail folders for an e-mail from CMS National Provider Calls.

This call is being recorded and transcribed, and an audio and written transcript will be posted to the CMS National Provider Calls and Events page within the next few weeks. A direct link to the page where these materials will be posted is also included in the e-mail that went out to all registrants earlier today.

I'd like to thank all of you that submitted questions for today's call; your questions were shared with the speakers to help them prepare for today's call.

I'm happy to introduce our speakers. From the Office of E-Health Standards and Services, we have Travis Broome, who is a Policy Analyst for Meaningful Use; Maria Michaels, who is the Acting Technical Lead for HITECH Clinical Quality Measures in the Center for Clinical Standards and Quality; Jason McNamara, Technical Director for Health IT in the Center for Medicaid and CHIP Services; and that is it.

So our agenda for today: Travis will be providing an overview of the rule and say a few words about eligibility for the program; he'll also talk about Meaningful Use. Maria will follow with a discussion of clinical quality measures. Travis will come back on and talk about payment adjustments and hardship exceptions. Jason will talk about Medicaid changes.

And with that—and then we'll open the line for your questions. And with that, I'll turn the call over to Travis.

Presentation

Overview of the Rule, Program Eligibility, and Meaningful Use

Travis Broome: Thanks, Diane. And let me go ahead and apologize ahead of time in case you guys end up with a cough or snuffle or two. I'm based out here in Dallas, Texas, where we, you know, have 70-degree weather one day and snow the next, and it's been playing havoc with my sinuses. But for that, we'll get right into it.

Going on to slide 2, which is basically our disclaimer. All this is current as of today, but we do provide sub-regulatory guidance in the future, which may update some of the things we talk about.

So we kind of lazily refer to it as the Stage 2 rule. But as you can see on slide 3, there's much more in the rule than just Stage 2 of Meaningful Use. We do have some changes to Stage 1. We do, of course, have Stage 2 of Meaningful Use. We have our 2014 clinical quality measures and changes to how those measures are reported. We have all the information about the payment adjustments and hardship exceptions, Medicare Advantage program changes, and Medicaid program changes.

Slide 4: What is Stage 2? What do we hope to accomplish with Stage 2? What does it mean to you? There are some new criteria. So after you've been participating in the program for 2 or 3 years, there are some new things that you'll need to do with your EHR to meet Meaningful Use. Most of those new things, as well as some of the things we've changed from Stage 1, really focus on three areas: clinical decision support, care coordination, and patient engagement. And we'll go into more detail in those in the future.

And then, as we focus on those things, we're going to save money, time, and lives with the next stage of EHRs, because really—then moving onto slide 5—but before we get into the details of Meaningful Use and how it's going to accomplish all those things, I'll talk a little bit about eligibility for the program. So who's eligible for the incentives, and who's looking to avoid the payment adjustments?

For the most part, eligibility is completely determined by the law itself, which makes our jobs here at CMS pretty simple when it comes to eligibility because we just basically rewrite what was in the law, covering the same folks that were outlined in the law.

The only things that are really in our purview are the determination of hospital-based eligible professionals, which I'll talk about in a second, and then also the patient volume eligibility requirements for participating in the Medicaid side of the program. And Jason will talk about those later.

On slide 7: The change to the hospital-based eligible definition. For those who don't know, hospital-based eligible professionals are not eligible for the incentive payment, nor are they subject to the payment adjustments by virtue of spending 90 percent or more of their services in the hospital. Because they spend so much time in the hospital, they're

using hospital systems, and the hospitals are incentivized themselves directly to provide those systems.

However, for EPs who might practice in the hospital 90 percent of the time but still provide their own EHR—so they fund the acquisition, implementation, and maintenance of certified EHR technology, and they use that EHR instead of using the hospital’s EHR—they can apply to us to basically have their hospital-based status revoked. And if they are successful, they will then be eligible to receive incentive payments and be subject to the payment adjustments.

All right. Now we’re going to move into talking about Stage 2 of Meaningful Use. Slide 9 shows where we are in terms of the framework of Meaningful Use, the overall framework of Meaningful Use Stage 2. Stage 1 is really getting the data we need into EHR technologies and testing our ability to use it and share it.

Stage 2 is all about using the data. So what processes are actually going to use the information that we spent the last 2 years collecting—3 years if you start in 2011—collecting, structuring, updating, ensuring its accuracy, all those things? Now we’re actually going to put in place the processes that we believe will actually use that data to—and you can see there in Stage 3—actually lead to improved outcomes.

For the next few slides, starting on slide 10, we’re going to walk through the Meaningful Use path. The most important thing to remember about the Meaningful Use path is that it is individual to every EP; it is individual to every hospital.

You start in Stage 1. You get 2 years in Stage 1, a minimum of 2 years of Stage 1. 2011 folks, they get 3; everybody else gets 2. Then 2 years of Stage 2, and then, moving to Stage 3, assuming, you know, we get a published Stage 3 in place in time. This is true whether you started in 2011, with the one exception you can see on the slide, or if you start in 2019. It doesn’t matter, the path is the same: 2 years in each stage, and you start whenever you start Meaningful Use.

Slide 11: Same outline, but for hospitals. The only thing of note for our Medicaid folks is that they can have as much time as they like between doing adopt, implement, and upgrade, and Meaningful Use. And then their program, by law—unlike the Medicare program, they’re allowed to skip years. So when they skip years, they kind of halt. Just as they aren’t penalized in their payments, they’re not penalized in their Meaningful Use progression either.

Slide 12 highlights some of the changes from—at a broad level of Stage 1 to Stage 2. As you can see, the overall number of objectives stays the same; however, there is a decided shift from the menu to the core. So the number of core objectives go up, the number of menu objectives went down. Still looking to do 50 percent of the menu, but it’s 3 of 6 instead of 5 of 10—excuse me—that was—that’s accomplished in two ways.

One: We got rid of a few objectives, we did some consolidation of some objectives, and then we added in new capabilities, as I mentioned earlier, and that's how we stayed within the total number. And you'll see those things illustrated on future slides. But before we get into individual objectives and measures; on slide 13, we're going to talk about some of the changes to the overall policies of Meaningful Use, as opposed to specific objectives and measures.

On the left side of the slide, you can see the changes. There's a change in how we deal with menu objective exclusions. So for those not familiar with Meaningful Use, most objectives are—come with two pieces. You can meet an objective, either by meeting the measure or by meeting the criteria for the exclusion. Prior to 2014, when you met the exclusion criteria of a menu objective—that counted toward the number you need to do. So it's 5 out of 10 in Stage 1. Prior to 2014, if I met the exclusion for 1 of the 10, it would count towards the 5.

Starting in 2014 and beyond, and for the future in all stages, it would no longer count toward the 5. So if I met the exclusion for one of the 10, now I would have to do 5 of the remaining 9, and so on and so forth, until I got to the point where I was only having to do 5 out of 5, in which case, then, exclusions would start counting towards the 5.

On the right side of the slide are the “No Changes.” So 50 percent of your encounters still need to be at locations equipped with certified EHR technology. “Equipped”—we put out a lot of better guidance this time around on what it means to be equipped. Equipped simply means that—can be one of three ways: You could either—you know, the location could have their own certified EHR technology; it could be established there and used there. A location could be equipped with certified EHR technology because a clinician, an eligible professional, brought it with them. They brought their iPad, they brought their laptop, and they can access their EHR securely. Finally, the third way a location might be equipped with certified EHR technology: Maybe you don't bring your own laptop or don't bring your own iPad, but you use the computers and resources at the location to remotely access your certified EHR technology.

Again, measure compliance, just as it did for Stage 1, always equals objective compliance. So if you meet the measure, you've met the objective for that stage.

And then finally, denominators are based on outpatient locations that are equipped with certified EHR technology, and you only have to worry about those locations that are equipped. You only have to worry about those outpatient locations. But if the location meets both of those criteria, it must be included in the eligible professional's Meaningful Use calculations.

Slide 14: Some more changes in 2014, some overall things. Unlike stages, the stage of Meaningful Use you are in—where it depends on when you start—certified EHR technology is fixed in time. So, starting in 2014, to have certified EHR technology, you must have EHR technology that's been certified to standards and certification criteria that ONC, the Office of the National Coordinator of Health Information Technology, adopted

in their final rule. This is regardless of what stage of Meaningful Use you're in. In 2014, everybody needs 2014-edition certified EHR technology.

Number two is really just a reaction to number one. And because of that, we lengthened the reporting period—or, sorry, we *shortened* the reporting period in 2014, because essentially everyone has to upgrade all in the same year. We knew that we didn't want everyone doing that all on the same day—you know, October 1st, all the hospitals have to go; January 1st, all the eligible professionals have to go. That would be a huge lift by the industry and by providers. So, to spread that out, we have shortened the reporting period for everyone in—regardless of stage, whether Stage 1 or Stage 2—in 2014, from a full year to 3 months. And this is only for our folks who have attested before. If it's your first year—regardless of what year—be it 2014, be it 2017, be it 2013, you get your any 90 days. After your first year, it's the full EHR reporting period. And except in 2014, where it's the 3 months, as opposed to the full year.

Last big change, overall change, before we get into Meaningful Use itself: Batch Reporting. Stage 2 rule allows for batch reporting. So starting in 2014, groups will be allowed to submit attestation information for the individual EP performance, so we still want to know how Dr. Smith did. But rather than having to punch in Dr. Smith's information on the Web portal, then punch in Dr. Jones, then punch in Dr. Jacob—whoever, so on and so forth—you can put all of their individual performance on one file and upload that file rather than individually attest.

All right. So that brings us to our core, the actual Stage 2 objectives. I'm not going to spend a lot of time on any individual objective, basically in the interest of time, so as to cover the rest of the rule. I will note that there are specification sheets—so, detailed two- to four-page sheets—for every one of these objectives for you to review, that are available on our Web sites.

There's two versions. There's a version that's geared toward providers, and then there's a version that's geared toward EHR developers. And of course, your—they are both available to everyone. You can use whichever you feel is better, but those are available for you to see.

So just to highlight of few things on this slide: CPOE expanding from just medications to laboratory and radiology orders; electronic prescribing going up just a hair, from 40 percent to 50 percent. Since it is now possible to prescribe controlled substances electronically, you can include controlled substances in your measure of e-prescribing, if you have that capability and if you desire to; you are not required to.

Demographics, vital signs, smoking status, all moving up from 50 to 80 percent. Clinical decision support going from 1 to 5. Again, the big focus area here for clinical decisions support—[I] highly encourage you to link specific rules to specific outcomes you want to see, specific clinical quality measures or other outcomes you actually want to see in your process. Incorporation of lab results, preventative reminders, things that are going to be very similar to what we had in Stage 1, just move to the core for Stage 2.

Slide 17: I am going to talk in detail about patient engagement and care coordination, so I'm going to skip over those on this slide. But just to highlight examples of patient engagement—patient access, visit summaries, education resources, secure messaging. We're talking about care transitions, we're talking about medication reconciliation, summary of care, immunizations, and really all the public health objectives moving from our testing world. You'll see that a lot. We're moving away from testing towards actual ongoing submission. There are still exclusions out there, so if your public health agency, for instance, can't take it—the information - then you obviously can't provide it to them if they can't take it. And similarly, if you don't give immunizations, obviously you don't have to report immunizations you don't give.

Privacy and security analysis, no big changes here. By far, the most important thing to remember about the security analysis is this is governed by the HIPAA security rule. Meaningful Use does not add any privacy and security requirements that are not already in place through HIPAA.

Slide 18 brings us to the menu objectives. Here you'll see a lot of some new things, so imaging results, family health history, cancer reporting, specialized registry reporting, and progress notes—all new for Stage 2. Syndromic surveillance was in Stage 1; however, its uptake on the EP side is so low we left it in the menu. So in addition to being included in the menu, you can see a lower threshold; these are newer measures moving forward.

Slide 19: Pretty much exactly the same for eligible professionals. The only difference there is on the very, very bottom: Electronic medication administration record—that's what eMAR stands for, for those who don't know. That's new to Stage 2. We're implementing it here, and that needs to be used for more than 10 percent of medication orders.

When your EHR is certified, it's certified with assistive technologies to help you with medication administration recordkeeping. And so we need those technologies to be in place for 10 percent of your medication orders.

Slide 20: As you can see, all of the public health measures—number 13, 14, and 15 (immunizations, labs, syndromic surveillance) went to core for hospitals. Everything else here will look very familiar, both from Stage 1 and from our discussion of EPs on Stage 2.

The hospital menu: again, seeing almost all new things here. So new lab results to EPs. So this is for hospitals that have—provide outpatient laboratory services, actually sending those lab results in a structured manner, electronically, to the ordering provider. Progress notes, imaging results, family health history look very familiar from our EP side.

Advance directives did stay in the menu. Main reason for this continues to be variation among State regulations and laws about the usability and affectability of an advance directive that only exists electronically.

And then finally the new one here for hospitals is e-prescribing. So 10 percent e-prescribing for discharge medication orders.

All right. So I said we're also going to take a closer look at patient engagement and care coordination. Patient engagement is an important focus of Stage 2. There are very detailed discussions in the rules about the weighing of the pros and cons and how we came about it—you know, covering the comments. So if you really want to get into the nitty-gritty of how we got to these measures, certainly I'll refer you to the rule itself.

But at its most basic, we came to the conclusion—we only want the conclusion slide—came to the conclusion that providers are in a unique place to influence the actions of their patients in regards to interacting both with their providers (so more than 5 percent of patients sending secure messages to their EPs), and then also patients interacting with and accessing their own health information (so more than 5 percent of patients must access their health information online). All this is on slide 22 for those following through.

The 5 percent threshold—we went back and forth a lot. And, like I said, if you want the nitty-gritty details, you can read all about it in the rule where we discuss in-depth on setting that threshold. In some communities and with some patient populations, making that information available, and you'll knock 5 percent out of the park, no problem; won't even require the providers to do much. In other communities, 5 percent might take a significant amount of effort on provider—the providers, excuse me. It might take a significant amount of effort on the part of the providers in the communities in order to reach the 5 percent threshold through educating and promoting—promoting the availability of the information. Rather than writing pages and pages and pages of rules trying to differentiate one patient population from the other, we chose just to go with the lowest threshold we could that still was essentially a threshold, at 5 percent. Even with such a low threshold, there is still an exclusion for providers who operate in counties with less than 50 percent broadband availability.

Slide 23 takes us a closer look at electronic exchange. And it's really a three-tiered system here for electronic exchange at summary of care. So this is getting a summary of care record, from the provider who is causing or ordering the transition of care referral, to the person whom they're transitioning the patient to or referring the patient to.

The first one, it comes straight from Stage 1 menu, and that's that the provider send their summary of care for more than 50 percent of transitions of cares and referrals. Using own—my own example here: I have a 2-year-old. Several months ago now, he had enough ear infections that he earned himself a referral to an ear, nose, and throat specialist. The pediatrician printed off a summary of care record, handed it to me, and said “When you go there, give them this.” That would meet the 50 percent.

It would not meet the second bullet on slide 23, which is the rule requires that the provider electronically transmit a summary of care record for more than 10 percent of transitions of cares and referrals using the standards of certified EHR technology.

So, to meet—for that same situation, to meet the 10 percent, the pediatrician, rather than handing me a piece of paper, would need to send a—what’s called a consolidated clinical document architecture summary of care record to the ENT electronically, using their certified EHR technology. If they had done that instead of handing me a piece of paper, it would also meet the 10 percent. So it would meet the 50 percent and the 10 percent.

The third bullet has to do with getting EHRs developed by different people to talk to each other. There are two ways to go about doing this. One is, if you have any one instance of a summary of care record sent electronically to a recipient with a different EHR vendor, then you’re done.

So, to continue with my example, if my pedia—my son’s pediatrician knew that he uses vendor X, and he knows that the ear, nose, and throat doctor who he electronically sent it to uses vendor Y, then he’s done—he’s now met the third bullet and he can forget about it.

If meeting that third criteria gets more complicated for providers than that, then we encourage them—CMS and NIST are setting up a test EHR system, and then you can just test with us. We obviously are different than your vendor. And that would also meet the third bullet.

The next few slides, I don’t really have much—too much to add, except what’s on the slides themselves. So I’m going to run through these pretty fast so I can hand it over to Maria for CQMs.

Changes to CPOE: We’re changing the denominator from the kind of proxy denominator, if you will, of unique patients with at least one medication, to the natural denominator, if you will, of the number of orders in the denominator, the number of orders entered using CPOE, Computerized Provider Order Entry, in the numerator.

Slide—actually 25 (it says 30 on the slide, but it’s actually 25) goes through changes to vital signs. This is just updating the measure to account for changes in guidance and blood pressure, and then getting rid of the age limitations for height and weight because frankly that never made sense, and then also revising the exclusion to allow blood pressure to be separated from height and weight.

Slide 26: Since in Stage 2, we were going to require you to do information exchange for 10 percent of the time, we’re going to assume in Stage 1 you’re doing some testing to get rid of that or get ready for that, so we’re getting rid of the requirement to test starting in 2013—so, now.

And slide 27: Again, everyone’s going to have 2014-edition certified EHR technology come 2014, regardless of what stage. In light of that, we’re updating the e-copy requirement to provide patients the ability to view, download, and transmit.

Please note that this is only providing the information. The requirement that 5 percent of patients access is not part of Stage 1; it's only in Stage 2. (Excuse me again.)

And finally, changes to Stage 1 in the public health objectives: This isn't really a change. We're just adding some clarity language. If you are in a situation where your public health agency will accept information, but they don't require you to send it to them, this is just clarifying that for meeting Meaningful Use, you need to send the information.

And with that, I will turn it over to Maria.

Clinical Quality Measures

Maria Michaels: Thanks, Travis. So, I'll be talking to you about clinical quality measures. I'll provide a general overview on the clinical quality measures for Meaningful Use and then go into some Medicare system aspects/ issues related to clinical quality measures. And my colleague Jason will then take you through the Medicaid side when he talks about all the Medicare changes later in this presentation.

So clinical quality measures are similar to certification in that when the version or the edition of certification changes from what they're referring to now as the 2011 edition, which we've been using in Stage 1, to the 2014 edition, the clinical quality measures will also change. Regardless of the stage of Meaningful Use that you're in, you would be required also to use the newer specifications that are certified according to the 2014-edition standards and certification criteria.

So, with that brief introduction, I'll move on to slide 30 and talk a little about reporting CQMs in 2013.

So more or less, the reporting for clinical quality measures will remain the same through 2013, which means that for EPs there will be 44 clinical quality measures. The reporting schema will be three core or alternate core clinical quality measures in the core and then three additional CQMs.

The minimum number of CQMs reported would be six, but up to nine if there are any core CQMs for which you have no patients in which to report any alternate core clinical quality measures.

On the hospital side, there are still 15 clinical quality measures, and the requirement is to report all 15 of those clinical quality measures.

In 2012 and continued in 2013, there are two reporting methods available for the measures that are included in the 2011-edition certified EHR technology. The first is attestation. That's basically the way that you all have been reporting clinical quality measures, and you can continue to do that through 2013.

If you would like to participate in an e-reporting pilot, we have one for EPs and one for hospitals. On the EP side, we have the Physician Quality Reporting System EHR

Incentive Program Pilot. And on the hospital side, we have the eReporting Pilot for eligible hospitals and CAHs. Both of those can be accessed through QualityNet.

For Medicaid providers, you would submit your clinical quality measures according to your State-based submission requirements, and, again, Jason is going to touch on that later in the presentation.

On slide 31: The CQM specifications in 2013 will not be updated, so that means that the specifications you've been using, you can continue to use. We did provide some updates that fixed some errors or issues that we found, so you are certainly welcome to use those, but they're not required. We're also providing some flexibility in implementing certified EHR technology, certified to the 2014-edition certification criteria, in 2013.

What that means is that you, as a provider, can report via attestation for CQMs that were finalized for both Stage 1 and Stage 2. So for hospitals that still includes all 15 of the clinical quality measures that were in the Stage 1 final rule. But for EPs, this only includes 32 of the 44 CQMs finalized in the Stage 1 final rule. And we've got listed on slide 31 the specific clinical quality measures that are excluded. And also, I would like to point out that since NQS number 0013 is a core CQM in stage—in the Stage 1 final rule, an alternate core CQM must be recorded instead, because it won't be in the certified EHR technology based on the 2014 edition. Again, the hospitals don't have to worry about that. All 15 of the CQMs are moving forward to Stage 2.

On slide 32: How the CQMs relate to the CMS EHR Incentive Program: Just wanted to point out that you may have noticed that CQMs are no longer a core objective of the EHR Incentive Programs beginning in 2014, but they are still a required part of the program. You do have to successfully report your clinical quality measures in order to demonstrate Meaningful Use.

Slide 33: A little bit of an overview on how we selected the CQMs and how we link them to HHS priorities. All providers must select CQMs from at least three of the six HHS National Quality Strategy domains. So those include patient and family engagement, patient safety, care coordination, population and public health, efficient use of healthcare resources, and clinical processes and effectiveness. So both EPs and hospitals have the requirement of covering at least three of the six of these domains in the clinical quality measures reported.

Slide 34: We have made a lot of effort in aligning some of our programs and the clinical quality measures reported in those programs, so we wanted to point out some of those changes that we've made. The commitment that we have at CMS to continue to work towards full alignment is still there. We do plan on continuing those efforts into the hospital programs—which we haven't quite gotten to yet at this juncture, but we are continuing to work with—including the same clinical quality measures in the IQR program (Hospital Inpatient Quality Reporting Program). You will hear, you know, in a few slides about the strides that remain on the EP side with having an option that aligns with the Physician Quality Reporting System. And we've also got some efforts with

CHIPRA and the Medicare Shared Savings Program including Pioneer ACOs. So, just a few of the ways that we're trying to work toward making reporting easier for all of you.

On slide 35: Continuing on the alignment path, we are trying to align more reporting mechanisms and identifying ways to minimize multiple submission requirements and mechanisms.

So, for EPs, we have included in the Physician Fee Schedule that the options that are available for the EHR reporting for PQRS are also available as the pilot for the EHR Incentive Program. This includes group practices beginning in 2014. So we do have two options that we have introduced, and so, if you're a PQRS GPRO or if you are participating in the Medicare Shared Savings Program or are a pioneer ACO, you do have options of reporting your clinical quality measures electronically, as long as they're based on certified EHR technology based on the 2014 edition.

On the hospital side, we have also included targets for completely aligning with the IQR program. Currently, we're expecting that in 2015 we will have an electronic reporting option in IQR that will also count in the EHR Incentive Program. The eReporting Pilot that is currently out there for 2012 and will continue in 2013 will be the basis for this electronic reporting in IQR. So if you have participated in that, you do have a flavor of what that will look like in IQR.

On slide 36: The electronic submission of CQMs beginning in 2014 for all Medicare eligible providers in their second year and beyond of demonstrating Meaningful Use, you must report your CQMs electronically to CMS. So attestation would not be an option if you are in your second or beyond. And for Medicaid providers, you report your CQM data to your State which may include electronic reporting. But, again, Jason will talk more about that later in his presentation.

On slide 37: A little bit more about CQMs beginning 2014. So a complete list of the CQMs required for reporting is listed on our EHR Incentive Program Web site. We've got a link for you there; it's actually currently posted, not in the future. And CMS will—or has included a recommended core set of CQMs for EPs that focus on high-priority health conditions and best practices for care delivery. We have nine on the adult side and nine on the pediatric side. So you—if you haven't gone through your CQMs already, you may want to look at those lists and see if some of those are cross-cutting enough to cover your specialty or process.

Slide 38: A little bit more on the recommended core CQMs for EPs. We selected the recommended core CQMs based on several factors. And they include conditions that contribute to the morbidity and mortality of the most Medicare and Medicaid beneficiaries; conditions that represent national, public, and population health priorities; conditions that are common to health disparities.

Moving to slide 39. Conditions that disproportionately drive healthcare cost and can improve with better quality measurement. Measures that would enable CMS, State, and

provider communities to measure quality of care in new dimensions, with a stronger focus on parsimonious measurement, and measures that include patient or caregiver engagement.

Slide 40: So changes to CQM reporting. We broke this down according to what happens before 2014 and what happens beginning in 2014. So this is kind of a summary of what I've already stated. For EPs up until 2014, you would report 6 out of the 44 CQMs, which includes 3 core or alternate core CQMs plus 3 additional or menu measures, clinical quality measures. And if you're a hospital, you report all 15 out of 15 clinical quality measures.

Beginning in 2014, EPs will report 9 of 64 clinical quality measures and must select at least 3 out of the 6 National Quality Strategy domains within those selected CQMs. And again, there's a list of 9 CQMs for adult populations and 9 for pediatric populations that you may choose to focus on when selecting your CQMs.

For eligible hospitals, we've increased the number of CQMs to 29, and the reporting requirement to 16 out of those 29. And once again, these must cover at least 3 out of the 6 National Quality Strategy domains.

On slide 41: This is a bit of a busy slide about the EP CQM reporting requirements beginning in 2014. One of the things I want to point out on this slide is that if you're an EP in your first year demonstrating Meaningful Use in 2014, you not only *could* attest but *should* attest, because there is a deadline of October 1st to submit to successfully participate in Meaningful Use in order to avoid a payment adjustment. So in order to be able to allow you to meet that deadline, we are setting the CQM requirement to attesting your CQM data for the 9 CQMs covering at least 3 domains by October 1st.

If you're an EP beyond your second year of Meaningful Use, you have essentially two options if you would like to report individually. Your first one would be—you could report via an aggregate method using a QRDA category 3 file to report your clinical quality measure data. And you also have the option of participating in option 2, which is essentially the option that aligns with the PQRS EHR reporting option. And you could use either a patient-level or aggregate-level file for that. The patient-level file is a QRDA category 1 and, again, the aggregate is QRDA category 3. And both of those options are electronic reporting.

As I mentioned earlier, we have introduced two group reporting options, and, again, these are for EPs beyond their first year of demonstrating Meaningful Use.

The first is if you're part of an ACO, and you participate in either the Medicare Shared Savings Program or you're a Pioneer ACO, you can submit patient-level data via a QRDA 1 or participate in the way that the Medicare Shared Savings Program or Pioneer ACO Program requires you to submit your data, but you have to use certified EHR technology, and it's got to be based on the 2014 edition.

Likewise for EPs that would like to use the PQRS group reporting options, whether that's through the GPRO Web interface or registry. You just basically have to follow the same type of criteria, use the requirements set forth by the PQRS group reporting options, and use certified EHR technology based on the 2014-edition standards and certification criteria.

Slide 42: For hospitals, CQM reporting beginning in 2014 and continuing into eventual alignment with IQR, the option that you have to report aggregate data is only for hospitals in their first year of demonstrating Meaningful Use for a very similar reason—in this case, because hospitals are on the Federal fiscal year, the deadline to submit your clinical quality measures in order to avoid a payment adjustment is July 1st. In order to be able to do that, you would have to use attestation as your method for submission, and the requirement will remain 16 clinical quality measures covering at least three domains.

If you are a hospital beyond your first year of demonstrating Meaningful Use, your only option is to submit patient-level data electronically in a manner similar to the current pilot. Again, the requirement is 16 clinical quality measures covering at least three domains.

Slide 43: In our interim final rule, we introduced a case threshold exemption for hospitals. It begins in fiscal year 2013 and applies to all stages of Meaningful Use. You must submit your admin data for each reporting period to justify this exemption. And we've included the threshold for exemption from reporting of CQMs during the relevant EHR reporting period, which we've outlined here.

In your first year of demonstrating Meaningful Use, you would be using a 90-day EHR reporting period and then using the threshold of five or fewer discharges within that reporting period. If you're in your second year or beyond of demonstrating Meaningful Use, you're required to use a full year EHR reporting period, and so your threshold becomes 20 or fewer discharges during that reporting period.

The threshold that you have to meet is defined by the CQM's denominator population, so those discharges have to apply for the population that is being captured in the denominator, and it applies on the CQM-by-CQM basis. So just because you meet the threshold for one CQM doesn't mean you're automatically excluded from others.

Slide 44: A little bit more about this case threshold exemption. If you would like to invoke the case threshold exemption in fiscal year 2013, all 15 of the clinical quality measures from the Stage 1 final rule are required. Therefore, you would be reducing the number of CQMs required to be reported by the number of CQMs for which you don't meet the case threshold of discharges. So, for example, if you have two clinical quality measures in the list of 15 that you have fewer than the threshold level of the discharges allowed, then you would have to report at least 13 of your clinical quality measures.

If you are trying to invoke the case threshold exemption in fiscal year 2014, this changes a little bit because the requirement is slightly different. Since you're required to report 16

CQMs covering at least three domains from the list of 29 CQMs, your process would be the same as in 2013, but in order to be exempted from reporting fewer than 16 CQMs, you would need to qualify for the case threshold exemption for more than 13 of the 29 CQMs. And then if the CQMs for which the hospital can meet the case threshold of discharges don't cover at least the three domains, the hospital would be exempt from the requirements to cover the remaining domains.

Slide 45: Just kind of a recap on the timing and different reporting and submission periods. For EPs, if you're in your first year of demonstrating Meaningful Use, your—actually, for both EPs and hospitals, your reporting period is at least 90 consecutive days. For EPs that would be within the calendar year; for hospitals that would be within the Federal fiscal year. Your submission period would then be any time after that minimum of 90 days all the way through to the end of the submission period.

So, again, for EPs, the submission period ends February 28th, right after the calendar year. And for eligible hospitals and CAHs, it's, again, anytime following the 90-day period but no later than November 30th of the following fiscal year.

The reporting period for EPs beyond their second year of Meaningful Use: It's the calendar year, the full calendar year—January 1st to December 31st. And for eligible hospitals and CAHs, it's the Federal fiscal year, so October 1st through September 30th.

The submission period for EPs is the 2 months following the calendar year, January 1st to February 28th. And for hospitals, it's the 2 months following the end of the Federal fiscal year, so October 1st through November 30th. That remains the same essentially as it currently is, so we just wanted to pull this out and make sure to let you know that there are no changes, and to clarify if there were any questions on any differences with the clinical quality measure time period.

Slide 46: One small exception to this rule is the 2014 year and quarterly reporting. In order to allow some flexibility for changing over systems to the 2014 certified EHR technology, we're allowing providers, Medicare providers, to report on a 3-month reporting period fixed to the quarter of either the fiscal or calendar years, depending on whether you're a hospital or an EP. And this will also hopefully help align with other CMS quality reporting programs.

One thing to note is that if you're trying to use an option that aligns with another reporting program, you do have to abide by the reporting period for that program. So for example, in PQRS, if the reporting requirement is to include a full year in order to get credit for that program, you would have to use a full-year reporting period in order to qualify.

So, we basically outlined the different calendar quarters for EPs and hospitals, and included the reporting periods, which are essentially the same for clinical quality measures—the same 2-month reporting periods as the full year and the same submission periods as well.

And, last but not least, slide 47: We have a few announcements and actually a couple of opportunities for input from everyone. We wanted to point out that the HIT Policy Committee put out an RFC, a Request for Comment, on Stage 3. The comment period is currently closed, but if you wanted to go back in and look at the required—or the questions that they put out there, you can go ahead and go in there. There's a lot of information in there with—to do with the Stage 3 definition of Meaningful Use, and includes questions on clinical quality measures.

CMS has put out a Request for Information for hospital e-reporting. The request includes hospital and vendor readiness for EHR Hospital Inpatient Quality Reporting data, and the comment period currently closes on January 22nd. However, in the next day or so there should be an extension posted in the *Federal Register*. We expect that extension to be February 1st, so you do have a little bit more time to get us your feedback, and we would very much appreciate it.

Then, just a heads up that CMS is also expecting to put out a Request for Information for EP e-reporting as well, and it will include questions related to the use of CQMs reported under PQRS, the EHR Incentive Program, and other reporting programs, and will also include some questions based on the American Taxpayer Relief Act of 2012. That's the fiscal cliff bill, for those of you following the news.

And then, a few more notes for the EP side. One of the things we wanted to bring to your attention is that the deadline to submit your attestation in 2013 for—excuse me, in 20—for the 2012 year, so currently in 2013—is January 31st, 2013, at 11:59 p. m. eastern time.

There will be a National Provider Call next week, on January 22nd, related to e-prescribing, so if you have more questions on that, you can dial into that call and ask your questions. We just wanted to point out that the attestation period, while still open for the EHR Incentive Program through February 28th, will end. If you want to claim the hardship exemption, that involves participating in the EHR Incentive Program. Once again, that deadline is January 31st, 2013, at 11:59 p. m. eastern time.

The other thing we wanted to announce to you is that there will be a scheduled power outage the weekend of February 22nd through 24th, 2013. That is later in the submission period. You would still have about a week or so after that to get your data in but we wanted to point that out because that would be a lull over 2 days essentially that you wouldn't be able to access the system for submissions. So we wanted to point that out so you can plan accordingly.

And with that, I would like to turn it back over to Diane for some polling.

Keypad Polling

Diane Maupai: Thank you, Travis and Maria. We're going to pause for a minute to complete keypad polling so CMS has an accurate count of the number of participants on the line with us today. 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. 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 you there are between two and eight of you listening in, enter the corresponding between 2 and 8. If there are nine or more of you in the room, enter 9. Again, if you are the only person in the room, enter 1. If there are between two and eight of you listening in, enter the corresponding 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.

And thank you for your participation. This concludes the polling portion of today's call. I'll turn the call back over to Diane.

Diane Maupai: Thank you, Holley. And I'm going to, in turn, turn it over to Travis on page 48, to talk about payment adjustments and hardship exceptions.

Presentation

Payment Adjustments and Hardship Exceptions

Travis Broome: Now that we've captured you all before we talked about payment adjustments, we'll talk about payment adjustments. There's really—payment adjustments and hardship exceptions are definitely part of the HITECH Act, the same way the incentives were. We tried to, wherever possible, keep it simple on how we operationalize the payment adjustments and hardship exemptions. To that end, there's really only four questions you really have to ask yourself or know to understand payment adjustments. How much are they? What do I need to do to avoid them? When do I need to do it by? And are there any exceptions?

So, "What do I need to do?" is on slide 49. And you need to do Meaningful Use. There is no special definition of Meaningful Use for this. It's the same definition of Meaningful Use and the same stages that I went through at the beginning of the program. The timeline—you know, when you do what stage, what stage you're in—it's the exact same whether you're going for the incentives or you're trying to avoid the payment adjustments.

Of note on the bottom: Adopt, implement, and upgrade is a way to get an incentive in—under the Medicaid program. However, it is not Meaningful Use, therefore it does not count for avoiding the payment adjustments. However, if you are attesting to Meaningful Use on the Medicaid side—for Meaningful Use, not AIU—that will avoid the *Medicare* payment adjustments.

All right, so how much are they? Unfortunately, the answer is somewhat, a little bit, “depends.” I’m not going to walk you through all these, in the interest of time and the ability to answer your questions, but basically you can just walk through and find where you belong on the chart.

The “brass tacks,” if you will, is they will never be more than 5 percent, as you can see on the far right on the top column of number 50, and they will always be at least 1 percent. How much they are is dependent on whether you are subject to the eRx payment in 2014, what year it is, and whether more than 75 percent of EPs are Meaningful Users by 2018. Considering we are doing very well in getting EPs signed on as Meaningful Use, we are certainly hopeful that it will be—more than 75 percent of you all will be there by 2018, because we are more than a third of the way there and it’s only 2013.

Slide 51 talks about when. So I know how much they are now, I know what I need to do, I need to do Meaningful Use—when do I need to do it by? That answer depends on if you’ve started or not. If you start Meaningful Use in 2013 or earlier, then it’s a rolling 2 years. So I’m a Meaningful EHR User in 2013, I’d only get the pay adjustment in 2015; ’14-’16, ’16-’18, and so forth, and so forth.

On slide 53: Then what I just said obviously begs the question, “OK. What if I’m not a Meaningful User by 2013?” If you are not a Meaningful User by 2013, then you need to become a Meaningful User in 2014, to avoid the payment adjustments in 2015, by October 1st. We need to know whether people are subject to the payment adjustments prior to the start of the year so that we can pay claims correctly at the beginning of the year. If we don’t know beforehand, we have to guess, and if we guess wrong, then we have to reprocess claims, and then we either owe you money or you owe us money. You all have to redo your accounting; we have to redo the claim. As you can see, this is starting to get very complicated and very expensive very quickly. So we need to make this prospective determination.

The last date that you can attest to Meaningful Use and avoid the 2015 is October 1st, 2014. Which means you need to start your 90-day reporting period—because by definition, this is your first year, so you’ll be in Stage 1 for 90 days—no later than July 1st, 2014.

Slide 54 is just a reminder: If you are eligible for both programs, if you demonstrate Meaningful Use in Medicaid, that will avoid the Medicare payment adjustment, but you must demonstrate Meaningful Use. So just because you were paid in Medicaid in the past, say in 2012 for Meaningful Use, that does not do anything for the payment

adjustments, but if you demonstrate Meaningful Use to Medicaid in 2013, that will avoid them for 2015 under Medicare; '14-'16, '15-'17, et cetera, et cetera.

So how much is it for hospitals? It's a decrease in the increase that they would otherwise get. So, if there is a percentage increase to the IPPS payment rate (that's the Inpatient Prospective Payment System), then you—that is decreased, if you're subject to the payment adjustment, by the percentages shown on slide 55.

When do you need to do it? Nothing shocking here. If it's 2013 or before, it's the 2-year rolling period, '13-'15, '14-'16, '15-'17, et cetera.

For hospitals: If you haven't been a Meaningful User by 2013, the last date to avoid—to attest is July 1st, 2014. Hospitals are on the fiscal year as opposed to the calendar year. So we need the same 3 months. But because it's the fiscal year, it's July instead of October, which means the hospital needs to start their 90-day reporting period no later than April 1st, 2014.

Critical Access Hospitals, they have a 1 percent—they get a 101 percent of cost reimbursement. They could potentially lose the 1 percent, on the schedule on slide 58.

When do CAHs need to do it? Critical Access Hospitals have a unique circumstance. We pay them on reasonable costs, not a payment schedule, and so that every year, we guess how much their costs are going to be, and at the end of the year, it's reconciled with what their costs actually were. That reconciliation makes the cost vary by far more than the payment adjustment does, far more than the 1 percent. So for that reason, we can use that cost reconciliation process to allow them to demonstrate Meaningful Use in the year of the payment adjustment and still apply the payment adjustment.

So, since we had the ability to do that for CAHs, we took advantage of it. We didn't want to penalize CAHs just because it didn't work for others. And all that timeframe is on slide 59.

Slide 60 starts talking about hardship exemptions; 60 is for EPs. There are five hardship exemptions. The three on the left are very obvious non-kind of Meaningful Use-specific things. So, you know, infrastructure—if you don't have sufficient Internet to do some summary of care records or care transitions, for instance, then obviously it'd be tough to demonstrate Meaningful Use, so there's—you can apply for an exception there.

New EPs: Because we are doing that prospective determination, we need to have our new docs, give them time to catch up to the prospective determination, the 2-year determination, so they get it a 2-year exception.

And then, unforeseen circumstances—Hurricane Sandy, you went bankrupt, your EHR vendor went bankrupt and stops supporting the system—all those things that we couldn't possibly list out in the rule—again, on an application basis.

The two on the right side of the slide are Meaningful Use–specific. Meaningful Use is possible basically for—for every eligible professional. We’ve had eligible professionals in nearly every specialty attest to Meaningful Use. However, if you do not have face-to-face or telemedicine interactions with patients, and you don’t have the follow-up need with patients, Meaningful Use is undoubtedly more difficult, because you are reliant upon other providers to give you information. You can’t go direct to the source easily like—the source being the patient.

So due to that reliance on other providers, combined with the still-progressing and hopefully jump-started by Stage 2 (but that remains to be seen), health information exchange environment, we decided that those two—that barrier—the difficulty in Meaningful Use caused by not having face-to-face interactions with patients and follow-up need—did rise to the rule’s standard of a significant hardship. So if you do not have those situations, if you don’t have face-to-face contact and you don’t have a follow-up need with patients, you can apply for a hardship exemption.

The other situation is EPs who practice in multiple locations. If you got EHR at 50 percent or more of your encounters, we already let you off the hook on the other 49.9 percent. But if you are in a situation where you practice in, say, an Ambulatory Surgery Center and in your office, and you spend most of the time at the Ambulatory Surgery Center, and the Ambulatory Surgery Center does not have EHR and you don’t have control over the availability of EHR at the ASC (i. e. , you just contract there, you don’t own it, for instance)—then you can apply for a hardship exemption based on that.

To apply for this one, though, you must practice at multiple locations, and you must demonstrate a lack of control over the availability of certified EHR technology. If you work at one location in a big office, and, you know, the employer doesn’t provide the EHR—well, the employer is probably the one who’s getting hit with the payment adjustments, not you, so there’s no hardship for that, because it’s working as intended.

Slide 61: For number 4, we determined in the rule that there were three specialties that could universally be said to lack face-to-face and lack follow-up need: Anesthesiology, radiology, and pathology. There is a FAQ out there that gives the specific specialty codes. Anesthesiology and pathology, it’s easy because there’s only one for each. Radiology, there are three: Diagnostic radiology, radiology interventionalists, and nuclear medicine.

Hospitals: Hospitals obviously don’t have the scope of practice variation that EPs have, so they just get the first three: infrastructure; new hospital; again, dealing with the prospective determination; and then those unforeseen hurt... circumstances—bankruptcy, Hurricane Sandy.

On slide 63: Applying for hardship exemptions. Hardship exemptions are based on circumstances in the year that you would attest. So 2013 is now available, so if you had attested in previous years, you’re now looking at circumstances could happen in 2013 that would allow for a hardship. Now, we do not yet have the application process open. It

will open this year. The deadline is April 1st, 2014, to avoid the 2015 or get an exemption for the 2015, and July 1st, 2014, to avoid the 2015 for EPs. So, as you can tell, lots of time ahead of us being able to apply for these hardship exemptions. But like I said, we're not going to wait till March 2014 to open this process; these processes will open up these years.

With that, I'm going to kick it over to my colleague, Jason, for Medicaid.

Medicaid-Specific Changes

Jason McNamara: Very good. Sorry, I was on mute. Thanks, Travis.

Hi. Good afternoon. I'm going to talk briefly on the Medicaid portions of the Stage 2 regulation. We took in a number of comments from providers and hospitals about expanding eligibility for our program. (I'm looking here at slide 65.) And the way that we were actually able to do this was to essentially expand our definition of what actually a Medicaid patient encounter is.

If you look at the Stage 1 regulation, the Medicaid encounter had to have some sort of financial liability to the encounter, so we looked at areas where an encounter may have had a cost-sharing premium paid, or a co-pay was paid, or Medicaid paid for all or part of the service.

I'm looking on slide 66 now. And so, if—and hearing our comments from providers and hospitals, we actually changed the definition of a Medicaid encounter, and in the Stage 2 regulation—and this is applicable to all stages—we're now looking at payments or, excuse me, the services covered to Medicaid beneficiaries. We're no longer concerned about payment liability. So this would include the infamous zero pay claims and encounters with patients under the Title 21-funded Medicaid expansions.

Moving on to slide 67: We have a lot of questions about what does the zero pay mean, and we leave that up for the State really to decide, but some very common examples have been listed here in front of you. We typically see claims that were denied because the Medicaid beneficiary had maxed out their service limit. A claim may have been denied because the service simply wasn't covered under the State's Medicaid program. The claim may have paid out at a \$0 because another payer's payment exceeded the Medicaid payment. Or the claim simply was denied because of a lack of timely submission of the claim.

So those are some various examples. There are a lot more out there, and we recommend that you reach out to your State Medicaid agency to actually work with them to figure out what information would go into your patient volume calculation.

Moving on to slide 68: One of the other areas that we expanded functionality was the CHIP encounters for inclusion into your patient volume calculation. Previously, under the Stage 1 regulation, we had CHIP encounters for patients that were strictly in the Title 19 Medicaid expansion program. Now and—with the Stage 2 regulation, and this is

applicable to all stages, we've included essentially Title 21 Medicaid expansion CHIP programs. But as before, encounters with patients in standalone CHIP programs simply can't be included in the patient volume calculation.

We understand that there is a lot of misunderstanding as far as what Title 19 or 21 or standalone CHIP programs for your State Medicaid programs. We recommend that you contact your State Medicaid agency to find out exactly how they have their CHIP program constructed.

Moving on to slide 69: One of the other areas that we provide some flexibility for providers is in the 90-day patient volume reporting period. Under the Stage 1 rule we looked at Medicaid patient volume for providers calculated in a continuous 90-day reporting period in the previous calendar year for eligible professionals, and the previous Federal fiscal year for eligible hospitals. In the Stage 2 rule—and this is applicable to all stages—States have now the option to allow providers to essentially calculate a 90-day reporting period in either of the last 12 months preceding the date of attestation, or they can use the 90-day reporting period in the previous calendar year or Federal fiscal year. And also we made some changes to the patient panel methodology. Before, we were looking at one Medicaid encounter taking place within the previous 12 months; we've since expanded that to a 24-month look-back period.

Moving on to slide number 70: Though we inadvertently in Stage 1 prevented about 12 children's hospitals from participating in the Medicaid EHR Incentive Program, this was simply because we assigned payments based on a hospital's CCN. If you are a Medicaid-only hospital specifically for children, chances are you don't have a CCN, so we inadvertently prevented those hospitals from participating.

Moving on to slide number 71: What we've essentially done is create a proxied CCN for these specific hospitals that don't have a CCN. To date, we've only had 4 hospitals out of the 12 have actually come to the table. The other 8 actually applied for a CCN and received their CCN number. But the policy framework is still in place to accommodate hospitals both now and in the future.

Moving on to slide 72: Keeping theme with our hospitals, in our Stage 1 regulation, we used some very esoteric language with the discharge-related amount base year in that hospitals had to use the discharge data from the hospital fiscal year that ended during the Federal fiscal year prior to the hospital fiscal year that served as the first payment year. As you can see, that was fairly laborious to try and figure out what data actually needs to be plugged in there. And so, in creating some administrative ease for our hospitals, starting in Federal fiscal year 2013 and later, hospitals can use discharge data from the most recent continuous 12-month period for which data is available for the payment year. What this essentially does for us is align us with the same sort of framework as the Medicare EHR hospital calculation.

Moving on to slide 73: You heard my colleague Maria talk about the clinical quality measures specific for Medicaid. While I won't go through all of these, I will say that we

took in a number of comments from the Stage 1 regulation as well as the Stage 2, about finding clinical quality measures and applying them for the Meaningful Use program that were specific to Medicaid beneficiaries. We heard you. We took into account some of these, and the measures you see in front of you right now on this slide are actually representative of that.

A couple of side notes: If you are a Medicaid eligible professional or if you are a Medicaid hospital, you will report your clinical quality measures directly to the State. The State has some options as far as how they want to capture the clinical quality measures. Unlike the Medicare eligible professionals, which are bound to eventually report electronically for clinical quality measures, the States are not in that same requirement. So you may—depending on which State you’re actually a part of, you may continue to report your clinical quality measures via attestation. There aren’t that many States out there that are electing to only use attestation, and they are setting up their framework and their infrastructure to capture clinical quality measures electronically.

If they are capturing clinical quality measures electronically, they’re doing it two ways. The first way is through their provider portal, and some progressive States are actually using their health information exchange to capture clinical quality measures, and then the health information exchange reports back to the State Medicaid agency. And we left the State to decide how and what level they want to actually report. So you may be reporting patient-level or you may be reporting aggregate-level patients—or, excuse me, aggregate clinical quality measure reporting, depending on your State. So once again we recommend that you reach out to your State Medicaid agency for these specifics.

And closing out on 20—on page 74, excuse me: We’ve modified our definition of “adopt, implement, and upgrade.” So, to align ourselves with the ONC certification for 2014 standards, it is no longer allowed simply just to attest using a certified EHR technology for adopt, implement, or upgrade. The certified EHR technology that you have obtained must take you to Meaningful Use.

And with that, I will turn over to Diane.

Question-and-Answer Session

Diane Maupai: Thank you, Jason. Before we open the lines for your questions, I’m sorry there’s not a lot of time left, but I will give you some resources and a number to call for additional questions.

Please, I just want to remind you that the call is being recorded and transcribed. And before you ask your question, please state your name and the name of your organization. I thank you.

With that, Holley, please open the lines for our first question.

Operator: To ask a question, press star followed by the number 1 on your touchtone phone. To remove yourself from the queue, please press the pound key. Remember to pick up your handset before asking your question to assure clarity. Please note: Your line will remain open during the time you're asking, so anything you say or any background noise will be heard in the conference.

And your first question comes from the line of Leslie Witkin.

Leslie Witkin: Hi. Good afternoon. Thanks for taking my question. Would it be a true statement that if an EP wants to achieve the EHR incentive, as well as PQRS, and in addition to having the certified EHR technology, they also would have to have a vendor that was either a direct EHR submitter or an EHR data submission vendor?

Maria Michaels: Thanks, Leslie. This is Maria. So, for 2013 as well as currently in the 2012 submission period, if you are using the eReporting Pilot through PQRS, the answer is yes. You would have to have certified EHR technology, as well as a vendor system that has been qualified through the PQRS program.

Leslie Witkin: OK.

Maria Michaels: In 2014, the requirement for both programs is to use 2014-edition certified EHR technology. So, beginning in 2014, you would only really need to make sure that your EHR technology is certified to the 2014 edition.

Leslie Witkin: So, no separate PQRS certification as of 2014. If it's a certified EHR, then they'll be capable of doing both CQM and PQRS?

Maria Michaels: That's right. The requirements are actually the same.

Leslie Witkin: OK. So, it's going to be the one format? Because PQRS has always been XML, but CQMs were the QRDA.

Maria Michaels: And the format will be QRDA.

Leslie Witkin: OK. Thank you very much.

Operator: And your next question comes from the line of Julie Cantor-Weinberg.

Julie Cantor-Weinberg: Hi. This is Julie Cantor-Weinberg with the College of American Pathologists. We're obviously very interested in the fourth category of eligible provider exclusions. And, Travis, there are actually two pathology specialty codes—22, which was included in the CMS FAQ last week, which is pathology; and 69, clinical laboratory billing independently, but those are independent pathologists. Do you know why 69 was not included in the FAQ?

Travis Broome: Sixty-nine, it was currently not included in the FAQ because we're still trying to determine if they're actually eligible professionals or not. But, yes, we are aware of that, and we're trying to work that out with the enrollment people and the lawyers, but there's somewhat of a question of whether they're actually considered eligible professionals, or kind of like pseudo-facilities. So as soon as I hear back from the lawyers, I will certainly—we will certainly spread that information wide.

Julie Cantor-Weinberg: That would be great. Thank you very much.

Travis Broome: OK.

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

Jennifer Montgomery: Yes. Hi. This is Jennifer Montgomery from Continuum Healthcare. In line with the PQRS question that came before, we were talking to our vendor about the possibility of submitting our 2013 PQRS in 2014. Does that—is there any conflict with the pilot at that point if we do that? I know there had been some issues with the pilot for PQRS and EHR in the past, and I just wanted to get clarification.

Dan Green: This is Dan Green from the PQRS team. So, the data for the pilot in 2013 would actually be submitted in 2014. So, that would be—that would be normal or standard operating, that you would collect the data in 2013 under the pilot, and if you're using a data submission vendor, they would send it in 2014. Or if you're using EHR direct, you would send it in yourself in the first 2 months of 2014. But, again, it would be the 2013 data.

Jennifer Montgomery: OK. So, we would have to be either in the pilot or submit it EHR, self-submission for that period? My understanding ...

Dan Green: You would be—if you want to participate in EHR in the Meaningful Use program and PQRS by definition, you'd be in the pilot.

Jennifer Montgomery: OK.

Dan Green: The only other way you could do it, of course, would be to attest for Meaningful Use and then submit solely for PQRS separately. The idea from the pilot—behind the pilot is to try to reduce reporting burden for eligible professionals.

Jennifer Montgomery: OK. Thank you.

Dan Green: Thank you.

Operator: Your next question comes from the line of Lisa Chase.

Lisa Chase: Hi. This is Lisa Chase with MicroFour, and we're an EHR vendor. You've mentioned a couple of times that starting in 2014 anyone participating in Meaningful Use

regardless of stage will need to be using a 2014 certified EHR. Is it going to be possible for vendors to test for Stage 1 only, starting in 2014? Or will all 2014 certified EHR products be certified for Stage 2 requirements?

Travis Broome: They're certified to the Stage 2 certification criteria. As part of that certification, they are—need to be certified to calculate both Stage 1 and Stage 2 measures. But, yes, there isn't a way to—yes, through modular certification, you could essentially choose not to do a new stage feature, and get a modular certification that doesn't include, say, electronic medication administration record, for instance, as something that's brand new for Stage 2. So you could do through our modular system, but if you want a complete certification, yes, you'd have to be certified to all the Stage 2 requirements.

Maria Michaels: And for ...

Lisa Chase: They're going to have to keep up. If they want 2014 certification, they're going to have keep up with the big dogs or fall out of the race essentially, right?

Travis Broome: Yes. I mean, there isn't a—they'll either have to keep up with the new capabilities or switch from a complete certification to a modular for the capabilities they have. We do expect modular will become more popular—for instance, the patient engagement piece with personal health records and portal and things—a huge modular area. Many people have products that just partner with other folks to do that and I imagine as ...

Lisa Chase: Right.

Travis Broome: ... capabilities get added, you'll see more and more of those partnerships to put together the complete, as opposed to—everyone doing a—their own complete thing.

Lisa Chase: OK. Cool. Thank you.

Maria Michaels: This is Maria. For clinical quality measures, I just wanted to point out that for 2014 all stages of Meaningful Use would require the 2014-edition certified EHR technology.

Lisa Chase: Thank you very much.

Maria Michaels: OK.

Lisa Chase: Thank you.

Operator: Thank you. Your next question comes from the line of Rhonda Slate.

And that question has been withdrawn. Your next question comes from the line of Karen Ross.

Karen Ross: Karen Ross from Michigan State University. If I have an EP who's contracted to work in an unrelated clinic, that also has a certified EHR as well as working in our own clinic, is it a requirement or just a suggestion to combine the Meaningful Use data for both EHRs to report?

Travis Broome: It's a requirement.

Karen Ross: It's a requirement. OK.

Travis Broome: Yes.

Karen Ross: Thank you.

Travis Broome: No problem.

Operator: And your next question comes from the line of Carol Choi.

Carol Choi: Hello, this is Carol Choi with an EHR vendor. My question is in regards to the expansion of the CPOE to certified medical assistants. I saw in your recently released FAQ that this will go into effect in 2013, but I submitted a request to CMS previously, where they told me the extension will not go into effect until 2014. So I just wanted to get verification of certified MAs performing CPOE.

Travis Broome: Right now it is effective for 2013 per the fact that—this is Travis. Sorry, you got that information before. But yes, it is available starting this reporting period—so basically, now.

Jason McNamara: And this is Jason McNamara. We recognized that we had a discrepancy with our call center scripts, and so we've since modified that.

Diane Maupai: OK. This is going to be our last question, Holley.

Operator: All right. Our next—our final question comes from the line of Cassi Kellett. Cassi, your line is open.

And that question has been withdrawn. Your next question comes from the line of Melissa Unger.

Melissa Unger: Hello, and thank you for taking my question. I reported previously, like back in April of 2012, that the CMS EHR system and attestation—registration attestation system was sporadically down throughout the day or kicked users out. And it had—it's been that way since April of last year, and with the increase of more organizations

submitting their attestations, I wanted to know if the bandwidth was going to be increased, or if another solution was going to be put in place?

Travis Broome: Well, we certainly—the contractor we have that runs the attestation site, they certainly do reliability testing. I don't know the results by memory to spout them off to you now, but we've done considerable testing for the system to handle the load this month and next month. As you can imagine, everyone—every EP in 2011 is coming back in, as well as all the EPs seeking to get their first year of payment when the payments have been maximized for 2012. So we've been doing a lot of reliability testing on it. We are certainly aware that that's the case. If you continue to run into problems, please report them to our information center, but we haven't—we are aware that the system is going to be taxed over the next six weeks, and we've been doing what we can to prepare for that.

Additional Information

Diane Maupai: Great. Thank you, Travis. I'm afraid that's all the time we have for questions today. I'd like you—to direct your attention to slide 75, which lists some of the resources we have on the EHR Web site. There's a dedicated page for Stage 2 that has a wealth of information on it. Also, if you have a specific question, and you can't find an answer on our Web site, feel free to call the EHR information center, and their number is 1-888-734-6433.

And on the last slide of our presentation, you'll find information and a URL to evaluate your experience with today's call. The evaluations are anonymous and confidential. So you will receive an e-mail reminder about the opportunity to evaluate the call from CMS National Provider Calls within two business days. If you've already evaluated the call, just disregard that e-mail. And that feedback helps us to serve you better.

So thank you, everyone, for participating in today's call. The recording and written transcript will be posted to the National Provider Calls and Events page on the CMS Web site within the next few weeks.

Again, my name is Diane Maupai; it's been my pleasure to serve as your moderator today. I'd like to thank Travis Broome, Maria Michaels, and Jason McNamara for their participation in today's call. Thanks and have a great afternoon.

Operator: Thank you for participating on today's conference call. You may now disconnect. Speakers, please hold the line.

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