Centers for Medicare & Medicaid Services
Medicare and Medicaid EHR Incentive Programs: Registration and Attestation for Eligible
Professionals National Provider Call
Moderator: Diane Maupai
September 9, 2011
1:30 p.m. ET

Welcome

Operator: Welcome to the Medicare and Medicaid EHR Incentive Programs: Registration and Attestation for Eligible Professionals National Provider Call. All lines will remain in a listen-only mode until the question and answer session. Today's conference call is being recorded and transcribed. If anyone has any objections, you may disconnect at this time. Thank you for participating in today's call. I will now turn the conference call over to Diane Maupai. Ma'am, you may begin.

Diane Maupai: Thank you very much and good afternoon, everyone. I'm Diane Maupai. I'm with the Provider Communications Group at CMS in Baltimore. I'd like to thank you for joining us today. If you haven't already looked it up, the presentation for today's call is on the CMS EHR website at cms.gov/EHRIncentivePrograms. You'll look on the left. You'll select Spotlight page. It is the second link under Presentations.

And I'd like to mention that that first link is a set of slides for the Clinical Quality Measures webinar that was held last week. Now I know a lot of people know we closed registration and a lot of people that wanted to, weren't able to get in. So this is the first information we'll be posting about that call. This is the slide deck but there are plans to repeat the call again in the next couple of months.

Also, if you missed our call on EHR Program Basics for Eligible Professionals in July, the audio recording, the written transcript and the slides are on that same site, cms.gov/EHRIncentivePrograms, on the Educational Materials page. Scroll down to Presentations for Providers.

Today's call is focused on registration and attestation for the incentive programs. There are a lot of resources about other aspects of the program on our website so I encourage you to go there, look at Frequently Asked Questions, the User Guide and all the other wealth of information, such as the Meaningful Use Specification Sheets. A lot of great information is out there.

I'm happy to introduce our speakers for today. They are Nichole Davick, from the Office of E-Health Standards and Services and also Jessica Kahn who's a

Technical Director in the Center for Medicaid, CHIP and Survey and Certification. It's going to be a little bit of a tag-team; Nichole's going to be doing the overview and Jess will be covering the Medicaid material. And after the presentation, we'll be opening the line for your questions.

With that, I'll turn it over to Nichole.

Slides 1 through 24

Nichole Davick: Thanks, Diane.

Welcome, everyone. This afternoon we will be talking about the Medicare and Medicaid Registration and Attestation Programs for Eligible Professionals. This presentation is long but most of the slides are screenshots. We wanted to give you this as a take-away for future reference. Several of you submitted questions when you registered for this call and we hope that the majority of them will be answered with this presentation. And there will be, as Diane said, a Q&A session at the end of the session for any other questions you may have.

Slide two is the agenda. The agenda includes Path to Payment, Highlights of the Registration and Attestation Process, Third-Party Proxy, Troubleshooting, Helpful Resources and a Q&A. Slide three is a graphic of the eligible professionals. They're grouped by Medicare-only, Medicaid-only and EPs that could be eligible for both the Medicare and Medicaid Programs. Slide four is the Medicare Eligible Professionals list. They must be a physician, have Part B Medicare allowed charges, must not be a hospital-based provider and be enrolled in PECOS in an approved status and living.

For more information on eligibility, visit the EHR Incentive Program website; the website that Diane just gave you. It's also at the end of this slide deck. It's important to register even if you've not enrolled or have a non-active status in PECOS. Registering for the EHR Incentive Program will alert PECOS to expedite your enrollment application. For help in determining if you are enrolled in PECOS, review the Medicare EP PECOS Notification download that's available on the EHR Incentive Program website under the Path to Payments link. Slide five is the Medicaid EPs. Jess.

Jessica Kahn: Thank you to everyone. So Medicaid eligible professionals do not have to be enrolled in PECOS. That is for Medicare eligible professionals and all hospitals but there is a separate set of professionals who are eligible for this program beyond the physicians. And, here, physician is limited to the definition of a Doctor of Medicine or Osteopathy. We also include nurse practitioners, certified nurse midwives, dentists and some physician's assistants. And that would be limited to those who work at a Federally Qualified Health Center or a Rural Health Center that is considered led by a physician assistant. And that's defined in our final rule from July of 2010, as a FQHC or an RHC, where that physician assistant provides the majority of services as the medical director. Or in the case of a Rural Health Clinic, is the owner of the clinic. Back to you.

Nichole Davick: On slide six, you're going to register for the EHR Incentive Program on that same website that Diane gave you earlier in the call and you're going to click on the Registration tab and you can complete your registration there. Slide seven is the Medicaid EP Registration. Jess.

Jessica Kahn: Sure. So as was mentioned, all providers come to this one front door for registration and there's some key information that we're going to go through that they provide here. And then, for those who are participating in the Medicaid program that information is sent directly to the States that have launched their EHR Incentive Program.

                   For those of you are eligible professionals and who are interested in registering for a State that has not yet launched its EHR Incentive Program, you will not be able to. You will not see that State name in the drop down menu. We do have information about States' timelines for launching their programs on our website but for the purposes of this slide, it's to point out that your registration information is sent through an automated file exchange with the State Medicaid Agency in the State where you reside. And they will take that information and populate their system and ask you to come back and complete the additional information, which we'll talk about in a little bit.

Nichole Davick: Slide eight is a screenshot of what the EHR Incentive Program website looks like. And you'll see in the left-hand side, the Registration Link is circled. Slide

nine also shows the Registration Link and the Registration User Guides. You're going to select Register for Medicare and/or Medicaid Incentive Program to start your registration process, and there's also a webinar on that same page that will walk you through the registration process.

Slide 10, Login. You're going to use your NPPES web user ID and password to log in. Your user name and your passwords are case-sensitive. If you don't have an NPI or NPPES web user account, you may navigate to the NPPES site. The link is in the body of the screen under the eligible professional's paragraph. CMS has implemented functionality that allows an EP to designate a third-party to register and attest on his or her behalf and we're going to go over that process later in this presentation.

Slide 11 is the welcome screen and that's going to display five tabs to navigate to. You have Home, Registration, Attestation, Status, and Account Management. You're going to choose the Registration Tab to begin. Also there's a Help Tab at the top of the screen for helpful tips navigating the system. Slide 12, the Registration Instruction screen, lists available actions for registration. The five registration actions available are Register, Modify, Cancel, Reactivate and Resubmit. The provider name and the last four digits of the EP's Tax ID and the NPI are all pulled from NPPES and they display on this screen.

Slide 13 is the Medicare Questionnaire. You're going to choose the Medicare radio button and you must click on the Apply button to accept the choice. Select your eligible professional type from the list of EPs that appears in the drop-down field. Answer yes or no to, "do you have a certified EHR?" And the certified EHR number is not required at registration but it will be at attestation. To find the list of products, you want to click on the "What is an EHR certification number" link at the bottom of the screen to be directed to the Certified Health IT Product List.

You can enter the EHR certification number if you have it. If you do have it, it is a case-sensitive number. It's an alpha numeric number. It's important to note that Medicare EPs cannot receive both Medicare EHR and e-prescribing

incentive payments. Medicaid EPs may enroll in both. Slide 14 is the Medicaid Questionnaire. Jess.

Jessica Kahn: Sure. So you'll see this is some of the same information regardless of whether you're a Medicare or a Medicaid eligible professional except that you would see this drop-down menu where you would select your State or territory and the provider types are a little bit different. The piece about the certification number for your Electronic Health Record technology – it is optional at registration and, as was noted, it would be required at attestation.

But if you have it, we strongly encourage you to enter it here and the State will pick up that information and populate that into your attestation once you receive that. Right now, we see – I think we queried our data most recently – about 40 percent of providers overall were populating that number at the optional registration points. And we just wanted to encourage people if they have it to please do enter it. It's not binding at this point; you can change it at the point of attestation but it does facilitate the process once that information gets sent to the States.

Nichole Davick: Slide 15 is Personal Information. It's the page where you're going to choose where your incentive payments should go. You're going to select your payment in the Payee TIN Type. And it's important to note that the EP's payment from the Medicare and Medicaid Electronic Health Records Incentive Program is made to the Taxpayer Identification Number selected at the time of registration. EPs will be paid in accordance with their Medicare payment designations. If the EP has assigned all of their Medicare benefits to another entity in PECOS (Provider Enrollment, Chain and Ownership System) then their incentive payment will also go to the group practice.

Since Medicare does not pay to provider's individual Social Security numbers, the EP would have to go in and select a sole proprietorship EIN in PECOS in order to have payment made directly to them. Slide 16 talks about the Medicaid Payment Assignment. Jess.

Jessica Kahn: Sure. So these are the same rules that apply to payment reassignments. There is one particular extra element with Medicaid and that's that in the statute,

6

Congress allowed for States to designate an entity that promotes EHR adoption as being eligible to receive provider reassigned payments. So in addition to being able to pick an employer, if the eligible professional voluntarily chooses, they could direct their funds to that entity that the State has designated as eligible for that.

Currently, I don't believe we have any States that have designated such an entity but that remains an option that they could do and we have some language in the rule – we talk about what kind of organizations that might end up being – but right now, we're seeing the majority of the payments go to the eligible professional themselves or to an employer.

Nichole Davick: Slide 17, the Business Address and Phone Number presented on the screen is the established practice location and number from NPPES. For EPs enrolled in the Medicare Incentive Program, the business name, the business address and business phone number will post on the website once a year of meaningful users receiving incentive payments. This information may be revised to post to the website and it will not flow back into NPPES. The address cannot be a Post Office Box and the e-mail address is required. States are not required to post the Medicaid payment information.

Slide 18 is the Registration Disclaimer. It's a document that states you accept and agree that your registration is true, accurate and complete. You want to click on Agree to submit your registration. If you click on Disagree, it will navigate you back to the Registration Instruction page. Slide 19 is the Successful Submission Receipt that you will receive upon a Medicare successful submission. You want to print the receipt for your records because you will not receive an e-mail notification of this. If your registration submission fails, you're going to receive a failed submission receipt. On that receipt there will be instructions that will give you contact information, telephone numbers and websites that will allow you to correct the information. Examples of a failed registration could be the EP is deemed hospital-based or their status in NPPES is deactivated.

Slide 20 is the Medicaid Successful Submission.

Jessica Kahn: Thank you. So, again, this information is going to the State. All this is telling you is that you have successfully registered. You should keep a copy of this. That information will be sent automatically to the State. The provider doesn't need to do anything additional to get it to go to the State. We recommend that you wait 24 hours and then go to your State's EHR Incentive Program website where you would have to enter additional eligibility information.

As you saw earlier, we're just asking very basic information from you at the point of registration but once you get to the State, you'll have to fill in the remaining information that we'll talk about that has to do with attestation. So, for example, there is where it would be binding for the EHR certification number. That's where you would attest to patient volume and to any of the other eligibility criteria that are particular to the Medicaid program.

And if there were any concerns around that, from that point on the communication is between the State and the eligible professional. The only time an eligible professional would need to come back to CMS at this point, from the Medicaid side, would be if they needed to alter any of the information that was provided at registration. So if you needed to change something there, your name or something in particular like that, you would have to come back to our system for registration changes. But anything from this point on is mitigated with the States.

Nichole Davick: Slide 21 is where an eligible professional may choose to switch between programs. They may do so only once after having received an incentive payment, and only before 2015. If the EP chooses to switch programs from Medicare to Medicaid, the EP must re-register.

Slide 22 shows the notable differences between the Medicare and the Medicaid EHR Incentive Programs. Slide 23, Medicare eligible professionals may reassign their EHR Incentive Programs to groups that are currently in PECOS. And you're only going to see the list of groups that are attached to you in PECOS in that list. Slide 24 displays the Medicare attestation screen. Medicaid EPs attest with their State, and you want to contact your State for more information.

The remainder of this presentation consists of attestation and third-party proxy access for Medicare only. We will have a Q&A session at the end of the call. So Medicaid callers have the option of staying on the line for the Q&A session.

And, Jess, is there something else you'd like to talk about in reference to attestation for Medicaid before I go on?

Jessica Kahn: No, I think we're good. We'll save it for Q&A, thanks.

Slides 25 through 68

Nichole Davick: OK. Slide 25 is the Medicare attestation instructions. The five attestation actions available are Attest, Modify, Cancel, Submit and Reactivate. And in order to begin one of the actions, the EHR Incentive Program registration must have a Medicare registration status of active. So you have to register before you attest.

Slide 26 - in order to complete your attestation you must complete all of the topics. And the system will display checkmarks for all of the items completed. On 27, on the attestation information page, you're going to enter the EHR certification number. And, as I noted before, that's case sensitive. It's 15 characters long, and we'd like you to check and make sure that the number you're putting in is correct, because we found some EPs making typos, such as using the letter I instead of the number one. To find your EHR certification number, visit the Office of the National Coordinator of Health Information Technology and their Certified Health IT Product List page. And that website is on the screenshot there. And then you're going to enter your reporting period for your attestation.

Slide 28 - there are 15 Meaningful Use core measures. Some of the measures will ask you to indicate whether data was extracted from all patient records or from patient records maintained using certified EHR technology. At the EP's discretion, the numerators and denominators of certain measures may be calculated using only the patient records maintained in the certified technology or the EP may elect to calculate numerators and denominators of

these measures using all patient records. EPs indicate the method they're going to use in their calculations.

Slide 29 - additionally, EPs can be excluded from meeting an objective if they meet the requirements of the exclusion. If the EP cannot meet the specific requirements, then the EP cannot answer yes to the exclusion questions. If no exclusion is indicated, the EP must report on that measure. Thirty shows a measure that requires only a yes or no answer. These objectives must be reported and there are no exclusions to reporting these measures. Clinical Quality Measures will be reported in another section.

Slide 31 - enter the numerator and denominator for the measure. Once you've completed all the 15 core measures, you'll be presented with the Menu Measure Questionnaire, which is on slide 32. You must report a total of five Meaningful Use menu measures. At least one of the five measures must be from the public health menu measures. Should the EP be able to successfully meet only one of the public health measures, they must select and report that measure to CMS and select any of the other four measures from the Meaningful Use menu measures.

If an EP meets the criteria for, and can claim, an exclusion for both public health measures, they must still select one public health measure and attest that they qualify for that exclusion. The attestation process is lengthy and you may log out at any point during the attestation and continue at a later time. All of the information you've entered up to that point will be saved within the module.

Screen 33 displays the public health measures. You must submit at least one Meaningful Use menu measure from the public health list, even if an exclusion is applied. Thirty-four - you must submit additional menu measure objectives until a total of five Meaningful Use menu measure objectives have been selected, even if an exclusion applies to all of the menu measure objectives that are selected. Only the five chosen measures will present for the next five attestation screens.

Slide 35 shows what the public health measure, menu measure one of two, looks like. And slide 36 is two of two. Slide 37 is a sample of a menu measure with exclusions. If you answer no to the question, "does this exclusion apply to you", you will get another question for the measure and answer the question to proceed to the next measure. Slide 38 is an example of a menu measure that requires the patient record selection, which means whether data was extracted from all patient records or only from the patient records maintained using certified EHR technology.

Slide 39 - once you've completed all five of the Meaningful Use menu measures, you'll be presented with the core Clinical Quality Measures or CQMs. Slide 40 shows the core Clinical Quality Measure screen. EPs must report CQMs directly from their certified EHR technology as a requirement of the EHR Incentive Program. Each EP must report on three core CQMs, four [*Post call clarification - speaker intended to say three*] alternate core CQMs and three additional quality measures. You will be reporting on a minimum of six and a maximum of nine. If the denominator value for all three of the core CQMs is zero, an EP must report a zero denominator for all such core measures and then must also report on all three alternate core CQMs.

Slide 41 - enter the denominator and numerator for the measures; that's just a sample screenshot there. Slide 42 - if the denominator, numerator and exclusion is applicable. And you'll notice that in the menu measures and the core measures, the numerator was before the denominator. The fields were entered – they were flipped. So when you see the CQMs, you're getting the denominator first and then the numerator. It's just the way the system was built. So on slide 42 you see that, besides the denominator and the numerator, you have the exclusion if applicable. And an exclusion reflects the patient population that did not meet the criteria of the measure, such as excluding diabetic patients allergic to aspirin. When you're reporting it on a CQM, it reports patients treated with aspirin as a preventative treatment for heart attacks.

Screen 43 - if you entered zeroes at any of the denominators for your core CQMs, you'll be presented with the alternate CQM screen. The screen will prompt you with the number of alternate core CQMs that you must select. In

the example on this screen, the EP entered zero in three core CQM denominators. Slide 44 - you're going to select three additional CQMs from the list. Shown here is just a partial list. Only the additional CQMs you selected will be presented on the screen.

Slide 45 - you will be prompted to enter a numerator, denominator and exclusions on the next pages. When you're finished with all that, you're going to get to slide 46, which is the topics for this attestation. Once you've completed everything the checkmarks will indicate that all of the topics have been completed. You're going to click on Modify Attestation to start the process from the attestation screen. If you click Modify, you're going to navigate back to the first page of the attestation module. Otherwise, you just click on Proceed with Attestation.

Slide 47, select any list table to review or revise your entries. You will navigate to the first page of this first series of the measures. And it's important to note here that this is the last chance that you have to review and edit the information that you've entered before you attest. Check your data for entry errors, as the system will not alert the user of a calculated percentage of the numerator and denominator prior to official submission of attestation.

Slide 48 - CMS recommends that you review all of your attestation information before submitting. EPs who fail their attestation can submit their attestation again and you can submit it for the same 90-day period. But if you choose to report on a different 90-day period it can be a day later versus March 1st, to May 31st – you can re-attest for March 2nd, through June 1st. But that means that you'll have to recalculate all of your numerator and denominator information again. Slide 49 just shows you how you can modify a menu measure individually.

Slide 50 is a screenshot of your summary of measures where you can review what you've entered. Slide 51 - check the box next to each statement to attest for the program and click on Agree to complete your attestation. This is the Attestation Statement screen. If Disagree is chosen, you will navigate to the homepage and your attestation will not be submitted. It's important to note here, though, that all of the information you've entered is still saved. Slide 52

is the Attestation Disclaimer. Read the disclaimer and click on Agree to continue your attestation or Disagree to stop your process.

Slide 53 is your submission receipt. This is going to complete your attestation. You want to print this receipt for your records because you will not receive an e-mail confirmation from CMS. Click on the Summary of Measures to view the summary and the detail of the core measures, menu measures and the CQMs. If you successfully attested, your attestation will read Accepted. And the attestation is locked and cannot be edited. Payments are scheduled to begin four to eight weeks after successful attestation and successfully meeting the $24,000 claims threshold. Providers attesting by the 15th of the month will receive payment approximately by the middle of the next month.

Screen 54 is an example of a rejected attestation. Again, print this receipt for your records because you will not receive an e-mail notification. If you want to review your entries, choose the Summary of Measures button. And, here on slide 55, is a screenshot of the Summary of Measures. Slide 56 lists what you need to do if your attestation was rejected. You want to reassess or modify your practice so that you can meet the measures, if you did not meet them, resubmit your attestation information again or resubmit new information or review your documentation if you found an error you can correct and resubmit. Or you may submit for a different reporting period during the first payment year to successfully demonstrate Meaningful Use.

Slide 57 - this portion of the presentation is about third-party proxy or users working on behalf of eligible professionals. Users are going to need to create an I&A web user account. And how to do that is on the login screen. You'll see the circle under Eligible Professionals, to create a login. It's important to note that States do not necessarily offer the same functionality for attestation in the Medicaid EHR Incentive Program. You want to check with your State to see what functionality will be offered. Instructions for navigating the I&A system are found in the Medicare EP Registration and Attestation User Guides.

Slide 58 shows the security check. You just have to answer two security questions to enter the I&A system. Slide 59 - you're going to create your user

ID, password and secret questions. And once you've successfully created a user ID and secret question and answer combinations, they're going to remain tied to your record and you cannot change them. Slide 60 - you're going to enter your user profile information. Sixty-one - Your employer's EIN, legal business name, and mailing address.

Slide 62 is going to show your current access for your request. In this instance, there are none on the screen. But if you have EPs, you'll be able to see the list there if you've requested access for. Slide 63 - you're going to choose the request type. And you're going to choose you are requesting to act on behalf of an individual provider. Make sure you check that. There've been some issues with this particular screen, people selecting Authorized User instead, please check that third bullet.

Another important note - a proxy user may only register and attest for 300 EPs. CMS is working to expand the limit to 1,000 and that will be in a future release. We're hoping October, late October. Slide 64 - choose the incentive program – the EHR Incentive Program in the Application Type box and enter the individual provider NPI to search for your EP. Sixty-five - choose the individual provider that you wish to access. You may choose one at a time or select all if they're a group of them. The EP has to approve your request in the I&A system before you can act as a proxy. And he or she will not receive an e-mail notifying him or her that you've requested access. You'll need to contact your EP and let them know you've asked for that.

Slide 66 is the Path to Payment Checklist. You want to make sure you're eligible. There's an eligibility wizard, as Diane said in the beginning, on the CMS EHR Incentive Program website. You've got to get registered - and register as soon as possible. You can register before you have a system installed. Visit the Office of the National Coordinator for Health Information Technology website for the list of certified EHR technology. Get your EHR certification number and finally attest to all of the measures.

Slide 67 lists the helpful resources. You want to visit that EHR Incentive Program website for further information on the program. Again, that's http://www.cms.gov/EHRIncentivePrograms/. There is a lot of information

there. Slide 67 and 68 offer help desk contact information, user guides and other resources for your reference.

That concludes our presentation. I want to thank you for your attention. Now we will open the phone line for questions.

Diane Maupai: Before we do that, I want to introduce Rob Anthony from our Office of E-Health Standards and Services, who will also be helping out with answering questions today.

Question and Answer Session

Operator: We will now open the lines for a question and answer session. To ask a question, press star followed by the number one on your touchtone phone. To remove yourself from the queue, please press the pound key. Please state your name and organization prior to asking a question and pick up your handset before asking your question to assure clarity. Please note your line will remain open during the time you are asking your question, so anything you say or any background noise will be heard in the conference.

Your first question comes from the line of Steve Miller. Your line is now open.

Steve Miller: Yes, I've just got a clarification. We are a little bit confused on the dates of attestation and registration. You know, if we want to get 2011, it said to register by October 1st, and we go ahead and do the attestation, there was a comment that the payments would be come – will be within four to eight weeks after that if it's successful. I guess I was under the impression that we need to do it for 90 days. Can that be clarified?

Rob Anthony: You do need to do a 90-day reporting period in your first year for Medicare. You don't need to register by October 1st [*Post call clarification- speaker intended to say October 3- this is reflected in the rest of the answer*]; you need to begin your reporting period by October 3rd, because you need to be able to fit those 90 days in before the end of the Calendar Year. You can register now. You can register the day that you decide to attest. I always

encourage people to register early because when you go through the registration process we do a number of checks and let you see if there are going to be any kind of issues that you need to sort out to get your registration properly processed.

So if you could register at this point in time, you can begin your reporting period October 3rd, that's the last day that you can get your 90 days in by the end of the year. And then you need to actually submit your attestation online within 60 days of the end of the Calendar Year. So it ends up being February 29th, of next year.

Steve Miller: OK. All right, thank you.

Rob Anthony: Sure.

Operator: Your next question comes from the line of Kevin Craig. Your line is now open.

Kevin Craig: Yes, Kevin Craig, Specialty Care LLC in Massachusetts. Can the 90-day data collection period straddle January 1?

Rob Anthony: No, it cannot. The 90-day period has to be within a single Calendar Year.

Kevin Craig: So if you can't make the 90-day starting October 1, through December 30th, or 31st, then wait until January 1, and start next year's data collection, is that correct?

Rob Anthony: That is correct.

Kevin Craig: Thank you.

Rob Anthony: I should specify the 90-day period is within the Calendar Year for eligible professionals. It is within the Fiscal Year for eligible hospitals, for anybody who is on for hospitals.

Operator: Your next question comes from the line of Maryann Baker. Your line is now open.

16

Maryann Baker: Yes, if you are unable to attest for 2011, do you need to then be able to qualify all 12 months in 2012, or can you qualify for three months in 2012 and attest to that and then 12 months in 13?

Rob Anthony: If you do 2012 as your first year of demonstrating Meaningful Use in Medicare, then it is a 90-day reporting period for you in 2012. Your first year is going to be a 90-day reporting period no matter when you begin it. Then your next year will be a full Calendar Year.

Maryann Baker: Thank you.

Operator: Your next question comes from the line of Harry Purcell. Your line is now open.

Harry Purcell: Hi, Harry Purcell with Medical Management Professionals. I have three, brief questions, if I could. First, on the registration, can you assign an address, such as a home address, or does it automatically default to the address associated with that NPI number?

Nichole Davick: You mean the address that you're entering in the registration?

Harry Purcell: Correct. And also where the payments would go to based on that registration.

Nichole Davick: You can enter your address on the registration for the posting to the website when you receive incentive payments. But as far as your payment address, that's the payment address that's assigned in PECOS already.

Harry Purcell: OK, that's associated with that NPI?

Nichole Davick: Yes, correct.

Harry Purcell: OK, perfect. Next question was - if someone, say, were to leave the group in the midst of this incentive payment period, how would that be handled? Would the group continue to receive the incentive payment, or would the incentive payment follow that individual to the next organization?

Rob Anthony: No, incentive payments are based on – they're paid to the individual eligible professional. If the eligible professional decides to reassign that payment to a

17

particular group, they can do that. But it is based on the performance of the EP so you wouldn't continue collecting. The eligible professional is going to have to continue to demonstrate Meaningful Use. So if they leave in the middle of a reporting period, they're going to have to pick up that reporting period at another practice with certified EHR and be able to meet all of the Meaningful Use objectives across both practices, and report all of that information in order to receive a payment. And they're going to be able to designate where that payment goes.

Harry Purcell: OK, perfect. And, final question - what about in the circumstance – I know there's a requirement that says you should report from the site where you perform 51 percent of your services. Let's say that the EHR has been achieved successfully at one set of sites but then the physician also spends some time – in my particular example, at some global hospital sites. How are you able to designate where payments are going to? Perhaps both – in this case, an imaging center and a hospital are both submitting successful EHR information – I'm sorry, the question's probably not clear but how would you split the payments between those two sites or recognize the location of service?

Rob Anthony: Again, the payments aren't made to practices. They are made to the individual eligible professional. The eligible professional can choose to reassign that payment. They can choose to reassign it to a single practice if they would like to; they cannot assign it to several practices. And I do want to clarify - it's not that you report out of the setting where you had 51 percent of your patient encounters. It's that you have to have had 50 percent or more of your patient encounters in settings that have certified EHR technology available in order to be able to demonstrate Meaningful Use. So you could have 20 percent somewhere, 20 percent in other setting and 10 percent in another setting but it adds up to 50 percent. If you are not able to conduct 50 percent of your patient encounters in areas where there is certified EHR technology available, then you wouldn't be able to demonstrate Meaningful Use.

Harry Purcell: Understood. Thank you so much.

Operator: Your next question comes from the line of Trudy Robles. Your line is now open.

Trudy Robles: Hi, my name is Trudy Robles and I'm calling from Rush University Medical Center. And I have a question that I currently came across, which is I currently have 151 providers, or EPs, that I'm requesting access for. And I keep getting an error message. If the current limit is 300 EPs, why is it that I'm only at 151 and I continue to get the same error message that I can't add access or, request access for the providers?

Nichole Davick: I would probably need more information from you, specific information from you, to figure that out. What is your e-mail address so I can contact you and get that information from you to figure that out?

Trudy Robles: Sure. It's "G" as in "girl", "E", "R" as in "Robert", "T" as in "Tom", "R" as in "Robert, "U" as in "umbrella", "D" as in "David", "I" as in "island", "S" as in "Sam", underscore, Robles, R-O-B-L-E-S, at XXXX.xxx.

Nichole Davick: I will contact you via e-mail and help you with this.

Trudy Robles: Great, thank you.

Operator: Your next question comes from the line of Deepak (inaudible). Your line is now open.

Deepak: I have two questions; one is that we are using the same software (inaudible) software for entering our hospital patients as well as our office patients. And I'm concerned that the denominator will change if we have the hospital patients in the same database. Because for them, we're not capturing any information which may be required for Meaningful Use. First question.

Rob Anthony: I think it's important to clarify that if you're an eligible professional, you have to use an ambulatory EHR in order to demonstrate Meaningful Use. Hospitals use an inpatient EHR. They are different systems. They are certified in different ways because there are different objectives for eligible professionals and eligible hospitals. There is some overlap in a number of those objectives, yes, but there are some differences in what's required. So if you're an eligible professional and you're using an inpatient EHR, you're not going to be able to demonstrate Meaningful Use for all of the objectives required because all of

the objectives that you would have to meet – that EHR isn't certified for, and vice versa for the inpatient. A hospital using an ambulatory EHR is going to be missing some of the objectives that it needs.

Deepak: Let me clarify. I am using an ambulatory EHR but for data entry purposes, for billing, for practice management, we do enter the hospital patients just for the billing part. But they are in the EMR database. So my question is the denominator would increase and the numerator would be still low because the numerator will be capturing information for the office patients only.

Rob Anthony: OK, I understand, thank you. So when you look at the measures for most of these objectives, the denominator isn't the number of records in your EHR. It's going to be the number of unique patients seen by the eligible professional. There are some of them like CPOE, well, CPOE isn't number of orders- most of them are based on unique patients seen. You occasionally will get something like transitions of care, where it's based on the number of transitions of care. So it won't be based the number of records that are in your EHR. You could have any number of records but you're really trying to limit your denominator pool for most of these to the unique patients seen during that reporting period.

Deepak: OK, thank you. And my second question was - in the presentation it was mentioned we are either eligible for e-prescription incentives or EHR incentives. Will you please clarify?

Nichole Davick: That is true. You can only – you can only participate in one or the other.

Jessica Kahn: For Medicare.

Nichole Davick: For Medicare, yes. Thanks, Jess.

Deepak: Thank you.

Operator: Your next question comes from the line of Cindy Watkins. Your line is now open.

Cindy Watkins: Hi, this is Cindy Watkins from Women's Medical Center in Michigan. My question is regarding Medicaid incentives. My understanding was we could apply this year, and because we were installing or implementing EMR, we would get paid this year. We could skip a year and then attest, is that correct?

Jessica Kahn: Sure. Let me explain. In a provider's first participation year in the Medicaid EHR Incentive Program you do not have to demonstrate Meaningful Use in order to receive that first payment. What is required is that you demonstrate that you've Adopted, Implemented or Upgraded to certified EHR technology that's capable of meeting Meaningful Use. So if you acquire access, you are financially and/or legally committed to having certified EHR technology, let's say, in 2011, this Calendar Year, and your State has launched their EHR Incentive Program, you would register here with CMS, that information would be sent to your State, you would complete the rest of the information that your State needs, including attesting that you have adopted or upgraded certified EHR technology, and that would make you eligible, assuming you met all those criteria, for your first incentive payment, which is $21,250, if you have 30 percent patient volume and you're not a pediatrician coming in at less than that.

So then, after that, for your second through sixth years, because you can participate up to six, you have to demonstrate Meaningful Use. You don't have to do it in consecutive years, like you said. You could come back in 2012 as your second year; you could come back in 2013 as your second year. You have through 2021 to complete six years for the participation, assuming that you start before 2016. Does that make sense?

Cindy Watkins: That makes sense. I just didn't know if I missed a piece there that said – because you're talking about attesting and receiving but nothing was mentioned about this piece of it, so I –

Jessica Kahn: Right. For this presentation, attestation was focused on Medicare and Meaningful Use, but the registration piece is the same for Medicare and Medicaid. And, as I said, attestation at the State level for Medicaid would be Adopt, Implement and Upgrade for the first Payment Year. And we have

some nice documents about a path for payment for Medicaid on our website that will take you through some of those terms in more detail.

Cindy Watkins: OK, thank you.

Operator: Your next question comes from the line of Barbara Sherman. Your line is now open.

Barbara Sherman: Hi, this is Barbara Sherman from MedHealth Medical Group. I was just wondering if you could just repeat – during the presentation you had indicated that if you attest by the 15th of the month that you should receive your incentive payment by – and I missed – I think you said a date in the following month, was it?

Nichole Davick: Yes, it's – if you attest by the 15th of the month, it's four to eight weeks after that you're going to receive your incentive payment. But what we've been seeing, generally, is about mid next month.

Barbara Sherman: OK. And then the one question that one of the previous callers asked was that you can only participate with either the eRx or the EHR, not both. But the eRx is part of the EHR, correct?

Rob Anthony: So, actually, we made a little bit of a misnomer there. You can participate in both programs; you can only get paid by one program at a time if you participate in the Medicare EHR Incentive Program. If you participate in the EHR Incentive Program, you will get deemed into the E-prescribing Program [*Post Call Clarification – providers participating in the EHR incentive program can request a hardship exemption to the 2012 eRx payment adjustment. The request must be received by November 1. See the Quick Reference Guide for more information.*]

. E-prescribing is also an objective of Meaningful Use within the EHR Incentive Program but that objective is different than the E-prescribing Incentive Program.

Jessica Kahn: Right, and again, for Medicaid providers they can receive both the e-prescribing incentive that was authorized under the MIPPA Act and the Medicaid or Medicare EHR – I'm sorry, the Medicaid EHR Incentive Program. It's for Medicare providers that they can't receive both incentives.

Barbara Sherman: OK, great. Thank you so much.

Operator: Your next question comes from the line of Dwayne Dennis. Your line is now open.

Dwayne Dennis: Good afternoon. My question is - can you describe – I've read that there is – there is the possibility of audits on the attestations and I was just wondering if ya'll could describe that process and if and when that happens, how that documentation is submitted, or can you just provide a little more on that? Thank you.

Jessica Kahn: Sure. In the final rule we require that all providers retain documentation of anything that they have attested to – so all of the eligibility, including Meaningful Use, for six years – a period of six years. Like any Federal program, probably like any State program, we have a responsibility to make sure that we're not making improper payments and so we are doing auditing and oversight of this program and expect the States to do the same for the Medicaid incentives. So, yes, providers will be audited for Meaningful Use. We will be working very hard to make that a process that is targeted and strategic and takes advantage of technology when possible and is coordinated with our other auditing and oversight efforts. And, again, the same goes for the States. Our recommendation is - if you have generated reports or other such documentation to support what you have attested to, that you keep that. Whether it's printing out the screenshot or keeping a copy of it, obviously, you have data within your EHR but some elements of Stage 1 can be supported from data that's not always kept in your EHR. So when in doubt, this is sort of like the IRS model, right? When in doubt, stick it in the shoebox; stick it in your closet and keep it just in case.

Dwayne Dennis: Got you. But may have a – I'd love to ask just a quick follow-up. As you said ya'll do that sort of strategically, you know, coordinated with other auditing efforts. Is it that ya'll use the esMD that RAC and MAC auditors are using to accept that documentation?

Jessica Kahn: That's interesting. We're certainly looking at the different ways that we collect clinical data from providers and trying to streamline that so that the same data

isn't submitted to CMS or its contractors in a duplicative way. Sort of as a concurrent discussion to this – if there is data that's available to us and we have the legal authority, then obviously that would be much more preferred than having to knock on your door or to do something that would have to involve contacting you in a more burdensome way. So whether it's data that's been submitted to us through other means, again, it has to be within our legal authority to use it for another purpose and sometimes we are not able to do that. But we are looking to be efficient about this, yes.

Dwayne Dennis: Got you. Thank you for taking the question.

Operator: Your next question comes from the line of Denise Cobb. Your line is now open.

Denise Cobb: Hi, I'm one of the – work with one of the Regional Extension Centers in North Carolina and we have a provider that their vendor is trying to get her to sign a paper saying that they will send the data in for her. My question being - I understand she's going from Medicare - years two through five is supposed to be seamless and invisible to the provider. But year one for Medicare, they do have to go back to the CMS website and do the attestation themselves, correct?

Diane Maupai: Hi, this is Diane. Actually, the Regional Extension Center – the place where your question should go, should be to the Office of the National Coordinator rather than here on this call.

Jessica Kahn: We can follow up with you since that is something that has to – We can follow up with you. We have some opportunities to take questions with the RECs and we will address that issue about proxy. We know that several vendors are looking to facilitate this process for their clients, as are many other entities. So let us follow up with the North Carolina REC to get you your answers, OK?

Denise Cobb: OK. And my comment to her was she's the one registering on the CMS site, she registered yesterday, so I thought she was going to have to go back and do the attestation herself.

Jessica Kahn: OK.

Denise Cobb: Because her vendor would not have her information, her personal user ID and
                  password.

Jessica Kahn: Correct.

Denise Cobb: I didn't understand how CMS would know who the provider was because they
                  weren't doing it straight underneath her provider name.

Jessica Kahn: OK, we'll follow up. Thank you.

Denise Cobb: Thank you.

Question and Answer Session Continued

Operator: Your next question comes from the line of Earl Bostic. Your line is now open.

Earl Bostic: Yes, I have actually four different questions. My first question is that I seem
                  to have an issue finding certified software for dental professionals and I
                  wanted to know what softwares are out there for dental professionals.

Jessica Kahn: There's currently only one certified EHR that's noted on the Certified HIT
                  Products List. Nichole showed on the slide deck where the URL for that
                  website is. There's only one; it runs on a Mac platform. We are in
                  communications with some of the other large dental EMRs, such as Dentrix
                  and others, to talk to them about their plans for becoming certified – likely to
                  be as a module, not as a whole EHR. And they are definitely actively working
                  on this and we're also collaborating with the American Dental Association to
                  look at how to encourage additional dental providers toward EHR adoption.

                  I should point out, though, that we have already paid a number of dentists in
                  other States under Medicaid for having adopted an EHR. And when we dug a
                  little deeper into that, what we found was – is that most of them are associated
                  with a Federally Qualified Health Center or some sort of multi-specialty
                  clinic. Because really they can achieve Meaningful Use using that, you know
                  – shall we say, more basic, generic, electronic health record. Does it have the

extra bells and whistles that provide the value adds as a dental provider? No, but it does meet the minimum that's necessary to demonstrate Meaningful Use in their case and receive an incentive payment. But we realize that that's not bringing you the value that you really want out of an EHR.

So, as I said, we're working with those dental EHR vendors to try and see how we can help facilitate their process so that they can offer you products that go beyond the minimum necessary.

Earl Bostic: OK. My next question is that after we do get everything squared away, how do we actually get to a live individual if we have questions concerning this? Because it's been a struggle for me to actually get in contact with someone to actually answer the question you just answered for me.

Jessica Kahn: Well, your Regional Extension Center locally is a great resource. They are very familiar with what products are available, what's certified. They might not know further than national discussions that I was alluding to but they certainly know what's available for different specialty types and how to go through vendor selection and those kinds of things. So we would encourage you to look for the Regional Extension Center in your area and give them a call. But you're also always welcome to contact us at CMS and we will get you answers to the right people.

Earl Bostic: OK. And how do I go about contacting you guys? Is there, like, just an e-mail?

Nichole Davick: We actually have – it's the EHR Information Center Help Desk. That information is on slide 68. But their number is 888-734-6433.

Earl Bostic: And the last question I had is, if I'm certified and eligible for payment, do we have to show purchase of the registration software or the certification software? Or, like you said before, can we just go through, like, a – like, a clinic and use their information and submit it that way?

Jessica Kahn: For the Adopt, Implement and Upgrade payment for Medicaid, you have to show that you have a financial and/or legal commitment to the EHR. And the reason we don't just say yes, everyone has to go out and buy it is because

many of us access software through our employer. We ourselves have not purchased something. So it would be through our – showing – demonstrating what our employer has done in order to get that. Or there are some EHRs that might be hosted by another entity and you just have a user license or some other kind of agreement. So the States are allowing people to demonstrate, Adopt, Implement and Upgrade through any variety of those kinds of documents that show that you are legally licensed to use that, or you have purchased it, or you have a contract or something like that. It can't just sort of be, you know, I have the intention of purchasing it, or something that's not binding. We want to show that you are bound to it but it doesn't have to be specifically purchased.

Earl Bostic: OK. I think that's the extent of all my questions. I appreciate you for everything.

Jessica Kahn: Good question. Thank you.

Earl Bostic: OK.

Operator: Your next question comes from the line of Liza Borozo. Your line is now open.

Liza Borozo: Actually, I had the same question as the previous caller. I'm a medical – I'm sorry, a Medicaid EP and I am completely stumped on how to get EHR certified technology. I've been in contact with our software, which is a Patterson Eaglesoft, which is fairly large in the industry, and they have no intentions at this moment of acquiring such technology. So I have no idea how to even go about getting a certification number.

Jessica Kahn: Right. Well, it's all really dependent on the vendor in that sense because, you know, that's how this process works. The vendors are meeting the certification criteria and getting those numbers to show that – what that software can do will meet Meaningful Use. It's that consumer reports, sort of, seal of approval to say that it's going to do what you have purchased it to be able to do. So if you're using Patterson or you're using another, sort of, EHR that has not gone through that process yet, then you're really at a loss unless you were to switch to something else that has gone through certification.

Liza Borozo: And with the previous caller, you mentioned something about other dental practices that have received payment and that is because they are part of another clinic you said - or something like that?

Jessica Kahn: Well, what's happening is that they're not stand-alone dental clinics. I mean, if I – you can imagine stand-alone dental clinics are going to want to purchase an electronic health record that supports dental care, right? That would make sense. But when you're a dentist that's in a practice with primary care providers, like a Federally Qualified Health Center or some other kind of multi-specialty practice, those kinds of clinics tend to buy a more generic electronic health record that can support the core functionality that everybody needs but it can't – it's not specific to dentists.

Liza Borozo: Got it.

Jessica Kahn: So, in that sense, it's enough for them to meet Meaningful Use; they don't have to do anything specifically dental related in order to meet Meaningful Use. There are some Meaningful Use measures that they can be – they can receive an exemption. So for Adopt, Implement, Upgrade, if they have access to certified EHR technology that meets Meaningful Use, that's enough for their payment.

Liza Borozo: OK, wonderful. Thank you so much for your time.

Operator: Your next question comes from the line of Sara Cornoyer. Your line is now open.

Sara Cornoyer: Thank you. My question was answered in a previous question. Thanks.

Operator: Your next question comes from the line of Debbie Belanje. Your line is now open.

Debbie Belanje: Hi, thanks. Once a provider registers for the program, is there anything on the registration that can't be changed prior to attestation?

Nichole Davick: No, you can change any of the fields that are changeable in the registration module but once it's locked for payment and once you've attested, it's locked for payment, you cannot change anything.

Debbie Belanje: OK, but up until attestation, we can change what program we put the provider in?

Nichole Davick: Yes, you can.

Debbie Belanje: OK. And if we don't intend to attest until, or for, Payment Year 2012, is there any reason we can't register in Calendar Year 2011?

Nichole Davick: No, you can register right now.

Debbie Belanje: OK, thank you.

Operator: Your next question comes from the line of Cathy Coleman. Your line is now open.

Cathy Coleman: Thank you. I'm from La Metra in San Francisco and this has been a really informative call. I wanted to share with the other people on the call that the help desk gave me a great tool related to some of the first questions, and it's called the "HIT Planner for Eligible Professionals", and it's a great handout that clarifies all the things that our speakers said in the first few questions about the dates. Because that can be really confusing.

Number two - the Medicare only eligible professionals – now, did I hear this correctly that nurse practitioners and PAs are not eligible for Medicare – the Medicare program?

Rob Anthony: That's correct. And, just to go back to the HIT planner, for those of you who are interested, that is available on our website. I believe it's under the Education Resources section.

Cathy Coleman: Yes.

Rob Anthony: So if anybody else is interested in looking at that, at the timeline, you can also download that there.

Cathy Coleman: OK, so, the NPs now, because – and there's no changing that, right? There are no changes anticipated? Because sometimes there's so many PAs and NPs, especially in California, but – just wanted to be clear that that was just physicians. In the Medicaid-only eligible professionals, if a nurse practitioner is joining a practice, there – under the eligibility it had, I think, 20 percent if you were a pediatrician. And that is strictly pediatrician, not a pediatric nurse practitioner?

Jessica Kahn;   That's correct. It's just pediatricians.

Cathy Coleman: Just physicians, OK. And, then, if the nurse came from another clinic and had a certified EHR there, and she had a certain percentage of patients, then if she saw a new percentage of patients in her new practice that added up to the total of 30, she could Attest, Implement, Upgrade – she could apply for that, right?

Jessica Kahn: Sure. And this is really not even specific to nurse practitioners but it's what happens when somebody joins the clinic, which is of course very commonplace. So if someone – patient volume is based on the prior Calendar Year. So for the 2011 payment, it's looking at a 90-day period in 2010, when someone had 30 percent or, in the case of pediatricians 20 percent. So for someone who joins this practice, say, last week, the question has come up, so what do we do? She wasn't with our practice so we don't know what her patient volume was, you know, in 2010. So what we have as an FAQ on our website that indicates, and this is part of our preamble discussion in the final rule from July, that that person can – they either, on their own, would need to demonstrate the patient plan from their prior site, which is fine, or we have an option under Medicaid for providers to add up all of the group's encounters and determine what the group's patient volume would be. And that would serve as a proxy for all the individuals.

Cathy Coleman: OK. And then each individual would still get paid.

Jessica Kahn: And each individual gets paid but they can use each other as a group, which makes sense when you might have somebody that was at 28 percent and somebody else was at 35 percent.

Cathy Coleman: Right, oh, that's good.

Jessica Kahn: But we know that patients come and see multiple providers often still within the same practice, so that seemed to be a reasonable proxy for overall patient volume.

Cathy Coleman: Yes, that's great. That's great.

Jessica Kahn: And you could include her if it's appropriate. And what we mean by that is if she's seeing Medicaid patients then it would be appropriate to include her and allow her to use that group proxy even if she hadn't been with the practice at that time.

Cathy Coleman: OK, and then if they decide not to do the group proxy and she sees 30 percent of her – she might only see 100 patients, so –

Jessica Kahn: It would still need to be from the prior Calendar Year.

Cathy Coleman: Oh, prior. OK, right. With a certified EHR?

Jessica Kahn: Not necessarily. The certified EHR could have happened since then. Patient volume is tied to the prior Calendar Year.

Cathy Coleman: Oh, OK.

Jessica Kahn: But Adopt, Implement and Upgrade – you know, it could take you 10 minutes to sign a contract. That could have happened the day before she attested.

Cathy Coleman: Oh, OK. All right. Thank you.

Jessica Kahn: Sure.

Operator: Your next question comes from the line of Sherry Reeves. Your line is now open.

Sherry Reeves: Yes, I'm Sherry Reeves. I'm with Hanover Regional Medical Center in Wilmington, North Carolina and I have three questions. One - we have been told by someone with our EMR vendor that if North Carolina was not going to

be ready for the public health question or – reporting options, that we needed to file for an exemption with CMS. And based on what I've heard today and what I heard on a previous call, and have read, I can't see where we have to file for an exemption; we just have to attest to it, is that correct?

Jessica Kahn: You are correct.

Sherry Reeves: OK.

Jessica Kahn: It's an exclusion. I would recommend that you look again before you attest to that at the public health website and determine what is and isn't available and make sure that they are not able to receive attests at this time. And then that would be the basis of your exclusion that you are attesting to.

Sherry Reeves: Yes, we've been told by our State they'll be ready by the time we attest but they're – the vendor's trying to – has been pushing us to do this exemption qualification. And I couldn't find where there was one to do so I'm OK with that. I just needed to clarify. The second thing is I'm a little confused when you say that the money is paid for EPs to the individual provider but then I thought I understood you to say that it actually – the checks will come to the group if they're registered under the group in PECOS.

Rob Anthony: The way that it works is that the program is set up so that individual eligible professionals are paid under the program and the EP can receive the payments themselves or they can have the payment made to another practice that – to which they're already associated with in our system.

Sherry Reeves: Right.

Rob Anthony: So if the EP during – and you would do this during the registration section. If the EP then designates a particular practice, that's who the payment will go to, whether that's check or ETF or –

Nichole Davick: And, one note there is if all of your Medicare assignments [*Post call clarification- speaker intended to say payments*] have been assigned to a group, then the group is going to receive the payment, not the individual provider.

Sherry Reeves: Right. So unless we go back and, in PECOS, change it to assign their Medicare payments back to the individual provider, then it follows where they're getting their payments.

Nichole Davick: That is correct.

Sherry Reeves: OK. And then, I just want to clarify – because I'm going to be registering a number of folks to get them on their established – or get them ready for this and I have to get them to allow me proxy not only for the attestation but for registration?

Nichole Davick: Actually, if they – if they give you proxy access, they give you the authority. They only have to do it once.

Sherry Reeves: Right.

Nichole Davick: You can register and attest.

Sherry Reeves: OK.

Nichole Davick: You're in the system once they say yes.

Sherry Reeves: OK, all right. That's all I have. Thanks.

Operator: Your next question comes from the line of Vicky Gormanly. Your line is now open.

Vicki Gormanly: Yes, hello. Thank you. This question sort of falls in line with one of the earlier questions but it's a little bit different. I'd like if you could confirm for me that in the – such as, diagnostic radiologists who are not hospital-based are indeed eligible professionals, they're required to comply, they would be subject to penalties if they don't, even if they are using and accessing qualified EHR that is equipped by, purchased by, maintained by, the hospital facility in which they work.

Rob Anthony: We do get this question a lot. Radiologists, anesthesiologists, people who are physicians, who would be considered eligible professionals, they are not

hospital-based – if you fall into that, then yes, you are eligible to participate in the program. If you choose not to participate in the program, then – and you are eligible, then you are subject to the payment adjustments at this point in time. So radiologists, conceivably, could receive incentive payments if they are using a certified EHR and meeting all of the Meaningful Use objectives and if they are not hospital-based and choose not to participate, then it is possible that they would be subject to payment adjustments. We know –

Vicki Gormanly: OK. So inaudible – if they're eligible, they are required to comply or –

Rob Anthony: It's not a question of requirement to comply; it is a voluntary program.

Vicki Gormanly: OK.

Rob Anthony: So, you know, you're certainly eligible to receive incentive payments if you meet those things. If you choose not to participate, there are payment adjustments that go into effect in 2015. We do know that there are issues for – specifically for this group of folks, radiologists and anesthesiologists, just because of the nature of their workflow. And we're currently looking into what we may be able to do as far as payment adjustments. But we anticipate we'll be able to look to announce something about that in the Stage 2 regulation, which is where we're going to detail that.

Vicki Gormanly: OK, great. And then – so then if the radiologist were to go on what – I'm looking at slide 13, where it says do you have a certified EHR? If they do have access through their hospital and they have an agreement, you know – be it a license or a – or a contract, they're accurate in clicking yes, we have, is that correct?

Rob Anthony: Yes, assuming they have access to an ambulatory EHR, which is what an eligible professional is going to need, yes.

Vicki Gormanly: Right, OK. So then – so then what you would envision at least, and I know you're going to address this in future regs – but what you're envisioning now is perhaps the radiologist or group would contract with the hospital for use of their ambulatory EHR?

Rob Anthony: I don't – I don't know that we're necessarily looking at that. I – it's certainly conceivable that radiologists, anesthesiologists, any of the number of groups who may not necessarily bill in an inpatient or emergency department setting, but do primarily their work in a hospital setting, could have an EHR and that EHR could be provided either through contract or through some other arrangement by the hospital or another organization. And there's nothing that prevents that under Medicare. It's simply a question of whether they can meet all of those objectives and they have access to that ambulatory EHR.

Vicki Gormanly: OK, that's really helpful. I appreciate it. If you happen to have any idea on a timeline for those second set of regs that would be great. Otherwise, I appreciate your help.

Rob Anthony: The notice of proposed rulemaking for the Stage 2 will be published – it's scheduled right now for the end of January 2012.

Vicki Gormanly: Thank you very much.

Question and Answer Session Concluded

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

Darlene Lackey: Hello, this is Darlene Lackey with Arkansas Health Group in Arkansas and I have three, quick questions. I have some providers that look like that we need to go the Medicaid path. And I just had, kind of, envisioned in my mind for 2011, we've upgraded to a certified EHR. So we would go ahead and attest for that. Then, if I understand what I'm reading correct, in 2012, we could attest to a 90-day consecutive period and in 2013, if we decided, we could go Meaningful Use for the full year?

Jessica Kahn: That's correct.

Darlene Lackey: OK, and –

Jessica Kahn: You can also, as I said, participate non-consecutively. But if you did straight through 2011 onward, that's how it would roll.

Darlene Lackey: We can do that. Also, I've seen in a couple of different documents where
Stage 1 has kind of been noted with 2011 and 2012. The next question is - is
there a maximum number of years that you're allowed to stay in each stage?

Rob Anthony: Yes, that's actually detailed partially in the regulation but, let's just say, in
general, you're going to have two years at each stage. So you would have 90
days – if you started your 90-day participation in 2011, that would be at Stage
1. And then you would have a year at Stage 1, again in 2012. And then, right
now, it is set up for 2013 to be Stage 2, and then 2014, to be Stage 2, so on
and so forth. If you started your Stage 1 in 2012, then you would have your
full year in 2013, and your Stage 2 in the beginning of 2014, and so on and so
forth. So, essentially, you're looking at about two years at each stage.

Darlene Lackey: Two years, OK. The last thing – I've just read some information and more
articles while researching that there's a possible delay in Stage 2, until 2014.

Rob Anthony: There was a recommendation by the Health IT Policy Committee, which is a
Federal Advisory Group that works closely with both CMS and ONC, and
their recommendation was that folks who were sort of the early attesters, the
people who had gotten in and attested in 2011, that they be given a one-year
delay for 2013, so that essentially, Stage 2 requirements wouldn't begin for
anybody until 2014 at the earliest. You know, again, we can't address those
things outside of rule making, so we really can't respond to it. I think there's
probably a general agreement within the community that that would be a great
idea and we're planning on releasing some information about that in the Stage
2, notice of proposed rulemaking at the end of January.

Darlene Lackey: OK, thank you so much.

Rob Anthony: Yes.

Operator: Your next question comes from the line of Roger Jordan. Your line is now
open.

Roger Jordan: Yes, this is Roger Jordan. I'm with the American Optometric Association.
And I enjoyed the presentation immensely but I have a quick question. With
optometry, I know we're listed as an eligible professional under the Medicare

program but under the Medicaid program you have listed primarily doctors of medicine and osteopathy – and that's primarily. Are optometrists allowed to participate and what's the process? And can States add them to their HIT programs?

Jessica Kahn: It helps to take your phone off mute. That's a good question. So there – it's a somewhat complicated answer but I'll give you the short version. And that is there are some States that could – that either have done or all States could, submit a State plan amendment to CMS to consider optometry services as physician – to be billed as physician services. And were that to be approved, they would be included under – they would be billed under the physician service.

Then that would make them eligible for the program as physicians. So, for example, Kentucky recently did make that request to CMS and it was approved. So optometrists are available – are eligible in Kentucky. To our knowledge, there are a few other States that are considering this but the vast majority, 98 percent, are not, only because that takes it out of the realm of what's considered optional services and puts it into required services. But, nonetheless, that is the only pathway for them to be considered physicians for the purposes of this program is if the Medicaid agency submits that State plan amendment to make that change.

Roger Jordan: OK, thank you.

Jessica Kahn: Yes.

Operator: Your next question comes from the line of Tracy Mack. Your line is now open.

Tracy Mack: Yes, I'm calling from Upstate Lung and Critical Care in South Carolina. I have one question and I forgot my other one. But I have – the question was - on their Meaningful Use core measures, where there's one of 15 on the patient records, how are you supposed to – if the records are extracted from – not all from your medical EHR, how can you prove – how can you have access to that? Or should they all just be from the electronic records?

Rob Anthony: There are certain of these measures that are based on all patients; there are certain of them that can be restricted just to patients whose records are maintained within certified EHR, and you have to take a look at each one of these to see which is which. But, in general, things like problem list, maintaining an active medication list, medication allergy list; those are based on all of the patients seen by the EP during the reporting period. Whereas the others can be limited to – I think, most of the others can be limited to patients whose records are just within the EHR.

Tracy Mack: And, a clarification - one of the gentlemen had spoken earlier – he mentioned that he has hospital patients. So you're saying if we were putting the, billing the charges for the hospital patients, they're not considered part of denominator or the numerator?

Rob Anthony: When you look at the denominators for most of these, the denominators are based on unique patients seen by the EP during the reporting period. When we talked about – if you look at the final rule - when we talked about these objectives and measures, we talk about applying them to patients who are seen but excluding the inpatients, which is POS 21, and emergency department, POS 23. So you're really looking at sort of ambulatory.

Tracy Mack: OK, but we do do a hospital follow-up a week after and then we may not see them again. So they're going to end up being in there and you don't have enough to do a whole bunch of Meaningful Use information.

Rob Anthony: Do you do a follow-up in the hospital or do you do a follow – I'm sorry?

Tracy Mack: They come to the office.

Rob Anthony: They come to the office. If they're being seen as an office visit, then they do count as a patient that is seen by the EP during the reporting period.

Tracy Mack: OK, and the other clarification question was - you said by the 29th, you had to attest to everything up to the 31st of the current year.

Rob Anthony: I'm sorry, could you repeat?

Tracy Mack: You have until February the 29th, to do your attesting up until the 31st of this year?

Rob Anthony: Yes, you have – you have up until 60 days after the end of the Calendar Year for EPs to get your attestation in via the website. So that ends up being February 29, 2012, as sort of, your drop-dead day.

Jessica Kahn: And, again, that's for Medicare.

Rob Anthony: Yes.

Jessica Kahn: States are determining what that attestation tale will be. The majority are mirroring Medicare and doing 60 days, though there are a few that are considering 90-day timeframes. And I encourage people to go to their State EHR Incentive website to determine what that last date of attestation would be for hospitals or for eligible professionals.

Tracy Mack: And, another question - if we have a physician that's decided just to go work in the hospital, not take patients in the office, we can attest up to their 90-day period for this year? They – say they'll start just going into the hospital just in November or October, but you've got to do your attesting prior to them going to do that, correct?

Rob Anthony: And so, you're saying that currently they're not hospital-based?

Tracy Mack: Right.

Rob Anthony: But you anticipate that they will be hospital-based and can they do their 90-day period prior to their becoming a hospital-based? Yes.

Tracy Mack: OK. OK, I think that's it.

Operator: Your next question comes from the line of Ian (Inaudible). Your line is now open.

Ian: Yes, thank you. Quick question or point of clarification for the adoption of EHR versus the actual attestation for the Meaningful Use piece. Do you have

to continue to attest after participating in the State Medicaid Incentive Program?

Jessica Kahn: If the question is, can you do Adopt, Implement and Upgrade in your first year and then not come back to attest to Meaningful Use in subsequent years?, then the answer is yes. And that's actually true of any element of the Medicaid or Medicare EHR Incentive Program. And that's that eligibility is determined each year. You must come back in and attest if you want the subsequent payment but there's nothing binding you to come back in the subsequent year. So you could do Meaningful Use for one year and we don't see you again, or you do Adopt, Implement and Upgrade and not come back for Meaningful Use. Each year stands on its own.

Ian: So the timeline that I'm looking at for the actual adoption, according to the Ohio State Medicaid Program, is for 2010 – January 2010, for that 3-month period for the implementation piece. I should also participate, is what you're saying, for – or I can, also participate for 2011, this year. So I would come back and I would attest for 2011?

Jessica Kahn: Right, well, the program only launched – Ohio's program, I believe, just launched.

Ian: It just launched.

Jessica Kahn: In May or in June and so, you would be attesting for the 2011 Payment Year. That's the first Payment Year you could receive that you'd have to have shown that you've done Adopt, Implement and Upgrade at some point before now. And, again, there's only been certified EHR technology since September of last year so you had to have done it sometime between September and now. And you would use your patient volume from the prior year, from 2010.

Ian: OK, so – then, the 3-month reporting period I shouldn't have selected January through March?

Jessica Kahn: OK, the – so the EHR reporting period only applies to demonstrating meaningful use. We do refer to a 90-day patient volume reporting period, which is not considered an EHR reporting period, and that's part of your prior

| | Calendar Year. And it's only to demonstrate Medicaid patient volume. So, in that sense, you could pick any 90 days within 2010, consecutively, that you had at least 30 percent or more patient volume, if you're not a pediatrician. But for Adopt, Implement and Upgrade, there is no EHR reporting period because it's not something you can – you know, you're not going to sign that contract really, really, really, really slow. You know, it's just something that you could do in a day. You could purchase it in a short period of time; it's not something that we're expecting a duration of effort. |

Ian: OK, so then, point of clarification - if after I've completed the patient volume, slash, implementation of EHR, I can then go back through the CMS website and attest for Meaningful Use?

Jessica Kahn: If you're applying for the Medicaid incentive, you would go to Ohio's website.

Ian: OK, so I continue to use Ohio's website?

Jessica Kahn: That's correct.

Ian: So after the actual – so after I've completed the process for adoption, then I go back to their website and complete Meaningful Use?

Jessica Kahn: That's right. For your second and subsequent years. For all of the attestation happens at the State Medicaid agency website. The only time you would need to go back to the CMS website is if you need to change something in your registration.

Ian: And, there, I would select the EHR, slash, the eRx incentive? If I'm participating for both?

Jessica Kahn: Yes.

Rob Anthony: Actually, you wouldn't select. It automatically pays one or the other, right?

Jessica Kahn: No, we're talking about the Medicaid.

Rob Anthony: Oh, I'm sorry, Medicaid.

Jessica Kahn: Right. So, again, the difference, though, is that the eRx incentive you are considered deemed for that if you have demonstrated Meaningful Use. So that wouldn't work for your Adopt, Implement and Upgrade year.

Ian: No, but it would work for –

Jessica Kahn: The subsequent year.

Ian: The subsequent – and that would be 2011? I would –

Jessica Kahn: If you do Meaningful Use in 2012. Because in 2011, you're doing Adopt, Implement and Upgrade.

Ian: Oh, I see. So I'm not eligible until 2012, for the Stage 1?

Jessica Kahn: Right. The States are not collecting Meaningful Use data in their first year because Medicaid providers can receive the incentive for simply doing Adopt, Implement and Upgrade. So they have been using this one-year period to bring those providers on, get them into technical assistance and support, while they're building their capacity to capture Meaningful Use data. The exception is dually-eligible hospitals that are demonstrating Meaningful Use.

Ian: Very good, thank you.

Diane Maupai: Thank you very much, everyone. We're out of time for questions today. I'd like to thank Nichole and Rob and Jess for the presentation and answering all your questions. And I would like to point your attention to slides 67 through 69 that have a lot of great links and resources and information for you. So have a great weekend, everybody.

Operator: Ladies and gentlemen, this does complete today's conference call. You may now disconnect.

END